

106TH CONGRESS  
2D SESSION

# S. 2342

To amend the Medicare program under title XVIII of the Social Security Act to make Medicare more competitive and efficient, to provide for a prescription drug benefit, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

APRIL 4, 2000

Mr. MOYNIHAN (by request) introduced the following bill; which was read twice and referred to the Committee on finance

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## A BILL

To amend the Medicare program under title XVIII of the Social Security Act to make Medicare more competitive and efficient, to provide for a prescription drug benefit, and for other purposes.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

3       **SECTION 1. SHORT TITLE; REFERENCES IN ACT; TABLE OF**  
4       **CONTENTS.**

5       (a) **SHORT TITLE.**—This Act may be cited as the  
6       “Medicare Modernization Act of 2000”.

7       (b) **REFERENCES.**—Except where otherwise specifi-  
8       cally provided, references in this Act shall be considered

1 to be made to the Social Security Act, or to a section or  
 2 other provision thereof.

3 (c) TABLE OF CONTENTS.—The table of contents of  
 4 this Act is as follows:

TITLE I—MAKING MEDICARE MORE COMPETITIVE AND  
EFFICIENT

PART A—COMPETITIVE DEFINED BENEFIT

Sec. 101. Competitive defined benefit.

PART B—PRIVATE SECTOR PURCHASING AND QUALITY IMPROVEMENT  
TOOLS FOR TRADITIONAL MEDICARE

- Sec. 111. Care coordination services.
- Sec. 112. Disease management services.
- Sec. 113. Competitive acquisition of items and services.
- Sec. 114. Provider and physician collaborations.
- Sec. 115. Preferred participants.
- Sec. 116. Centers of excellence.
- Sec. 117. Demonstration of bonus payments for health care groups.
- Sec. 118. Administration of certain private sector purchasing and quality improvement programs.
- Sec. 119. Reports to Congress on private sector purchasing and quality improvement programs.
- Sec. 120. Increased flexibility in contracting for Medicare claims processing.
- Sec. 121. Special provisions for funding of activities related to certain overpayment recoveries and provider enrollment and reverification of eligibility.

TITLE II—MODERNIZING MEDICARE BENEFITS

PART A—PRESCRIPTION DRUG BENEFIT

- Sec. 201. Prescription drug benefit.
- Sec. 202. Medicaid buy-in of Medicare prescription drug coverage for certain low-income individuals.

PART B—IMPROVING PREVENTIVE BENEFITS AND ELIMINATING COST  
SHARING

- Sec. 221. Elimination of cost sharing for preventive benefits.
- Sec. 222. Information campaign on prevention.
- Sec. 223. Smoking cessation demonstration.

PART C—RATIONALIZING COST SHARING AND MEDIGAP

- Sec. 231. Deductibles and coinsurance for clinical laboratory services.
- Sec. 232. Indexing deductible to inflation.
- Sec. 233. Updating and expanding Medigap plan options.
- Sec. 234. Report to Congress on options for improving Medicare supplemental coverage.
- Sec. 235. Increasing access to Medigap.

Sec. 236. Removal of sunset date for cost-sharing in Medicare part B premiums for certain qualifying individuals.

TITLE III—PROTECTING AND EXTENDING MEDICARE SOLVENCY

Sec. 301. Transfers to extend solvency.

Sec. 302. Catastrophic prescription drug coverage reserve.

Sec. 303. Medicare solvency debt reduction reserve.

Sec. 304. Protection of Medicare solvency debt reduction reserve.

1 **TITLE I—MAKING MEDICARE**  
 2 **MORE COMPETITIVE AND EF-**  
 3 **FICIENT**

4 **PART A—COMPETITIVE DEFINED BENEFIT**

5 **SEC. 101. COMPETITIVE DEFINED BENEFIT.**

6 (a) PAYMENTS TO MEDICARE+CHOICE ORGANIZA-  
 7 TIONS BASED ON RISK-ADJUSTED BIDS.—

8 (1) IN GENERAL.—Section 1853(a)(1) (42  
 9 U.S.C. 1395w–23(a)(1)) is amended by striking “the  
 10 Secretary shall make” and all that follows and in-  
 11 sserting “the Secretary shall make, to each  
 12 Medicare+Choice organization, with respect to cov-  
 13 erage of an individual for a month under this part  
 14 in a Medicare+Choice payment area, separate  
 15 monthly payments with respect to benefits under  
 16 parts A and B combined, and (as applicable) with  
 17 respect to benefits under part D, as determined in  
 18 accordance with this section.”.

19 (2) ANNUAL DETERMINATION AND ANNOUNCE-  
 20 MENT OF PAYMENT FACTORS.—

1 (A) IN GENERAL.—Section 1853(b) (42  
2 U.S.C. 1395w-23(b)) is amended—

3 (i) in paragraph (1), by striking “the  
4 calendar year concerned” and all that fol-  
5 lows and inserting “the calendar year con-  
6 cerned, the following factors, as defined in  
7 paragraph (4):

8 “(A) national monthly per capita costs,

9 “(B) the benchmark amount for each pay-  
10 ment area, and

11 “(C) the health status and demographic  
12 adjustment factors to be used in making pay-  
13 ment for individual enrollees.”;

14 (ii) in paragraph (3), by striking  
15 “monthly adjusted” and all that follows  
16 and inserting “such estimates, factors, and  
17 amounts”; and

18 (iii) by adding at the end the fol-  
19 lowing new paragraphs:

20 “(4) FACTORS USED IN ADJUSTING BIDS FOR  
21 MEDICARE+CHOICE ORGANIZATIONS AND IN DETER-  
22 MINING ENROLLEE PREMIUMS.—

23 “(A) IN GENERAL.—Subject to paragraph  
24 (5), the Secretary shall use, for purposes of ad-  
25 justing plan bids and determining enrollee pre-

1 miums under this part, the factors specified in  
2 this paragraph, which factors—

3 “(i) shall be calculated separately for  
4 benefits under parts A and B combined,  
5 and under part D; and

6 “(ii) shall be calculated separately  
7 for—

8 “(I) beneficiaries who are aged or  
9 disabled; and

10 “(II) beneficiaries who have end  
11 stage renal disease until such time as  
12 the Secretary establishes an inte-  
13 grated risk adjustment system for the  
14 groups specified in subclauses (I) and  
15 (II).

16 “(B) NATIONAL MONTHLY PER CAPITA  
17 COSTS.—

18 “(i) IN GENERAL.—The term ‘na-  
19 tional monthly per capita costs’ means  
20 (subject to clause (ii)) the projected na-  
21 tional, monthly, per capita costs of benefits  
22 under this title and associated claims proc-  
23 essing costs for individuals entitled to ben-  
24 efits under part A and individuals enrolled

1 in the program under part B who are not  
2 enrolled in a plan under this part.

3 “(ii) EXCLUSION OF DSH AND GME  
4 COSTS.—The calculation of costs under  
5 clause (i) shall not take into account any  
6 amounts attributable to—

7 “(I) payment adjustments under  
8 section 1886(d)(5)(F) for hospitals  
9 serving a significantly dispropor-  
10 tionate number of low income pa-  
11 tients;

12 “(II) payments for costs of grad-  
13 uate medical education under section  
14 1886(h); or

15 “(III) payments for indirect costs  
16 of medical education under section  
17 1886(d)(5)(B).

18 “(C) BENCHMARK AMOUNT.—

19 “(i) The term ‘benchmark amount’  
20 means, for a payment area, an amount  
21 equal to the greater of—

22 “(I) except as provided in clause  
23 (ii),  $\frac{1}{12}$  of the annual  
24 Medicare+Choice capitation rate that  
25 would have applied in that payment

1 area under section 1853(c) (as in ef-  
2 fect prior to the enactment of the  
3 Medicare Modernization Act of 2000);  
4 or

5 “(II) the product of 96 percent  
6 of national monthly per capita costs  
7 and the ratio, for a previous period,  
8 of—

9 “(aa) monthly per capita  
10 costs of Medicare benefits for in-  
11 dividuals entitled to benefits  
12 under part A and individuals en-  
13 rolled in the program under part  
14 B in that payment area (adjusted  
15 for relative risk due to health  
16 status and demographic adjust-  
17 ment factors) to—

18 “(bb) the weighted average  
19 for all payment areas of such  
20 monthly per capita costs.

21 “(ii) If the amount calculated under  
22 clause (i)(I) for a year for all payment  
23 areas is equal to either the minimum  
24 amount or the blended capitation rate, for  
25 all subsequent years the Secretary shall

1 not calculate the rates described in that  
2 clause and the amount under such clause  
3 instead shall be equal to the product of 96  
4 percent of national monthly per capita  
5 costs and the ratio of—

6 “(I) the annual Medicare+Choice  
7 capitation rate for the last year that  
8 such rates were calculated under such  
9 clause to—

10 “(II) the weighted average of the  
11 area-specific Medicare+Choice capita-  
12 tion rates for that same year.

13 “(iii) For years prior to 2005, with  
14 regard to benefits under part D, the Sec-  
15 retary may use 96 percent of national  
16 monthly per capita costs as the benchmark  
17 amount for all payment areas or provide  
18 for regional rather than payment area-spe-  
19 cific determinations of the benchmark  
20 amounts.

21 “(D) HEALTH STATUS AND DEMOGRAPHIC  
22 ADJUSTMENT FACTORS.—The term ‘health sta-  
23 tus and demographic adjustment factors’ means  
24 health status and such other risk factors as  
25 age, disability status, gender, institutional sta-

1           tus, and such other factors as the Secretary de-  
 2           termines to be appropriate, so as to ensure ac-  
 3           tual equivalence. The Secretary may add to,  
 4           modify, or substitute for such factors, if such  
 5           changes will improve the determination of actu-  
 6           arial equivalence, and in that event will make  
 7           comparable adjustments to the benchmark  
 8           amounts. For years prior to 2005, with regard  
 9           to part D benefits, the Secretary shall not be  
 10          required to include health status in the factors  
 11          described in this subparagraph.”.

12           (B) CONFORMING AMENDMENT.—Section  
 13          1853(c)(7) is relocated and redesignated as sec-  
 14          tion 1853(b)(5), indented accordingly, and  
 15          amended by striking all that follows “shall ad-  
 16          just appropriately” and inserting “national  
 17          monthly per capita costs for the following  
 18          year”.

19           (3) SUBMISSION OF BIDS BY  
 20          MEDICARE+CHOICE ORGANIZATIONS.—

21           (A) IN GENERAL.—Section 1853 (42  
 22          U.S.C. 1395w-23) is amended by striking sub-  
 23          section (c) and inserting the following new sub-  
 24          section:

1       “(c) SUBMISSION OF BIDS BY MEDICARE+CHOICE  
2 ORGANIZATIONS.—

3               “(1) IN GENERAL.—Each Medicare+Choice or-  
4 ganization shall submit to the Secretary, in a form  
5 and manner specified by the Secretary and for each  
6 Medicare+Choice plan which it intends to offer in a  
7 service area in the following year—

8                       “(A) by April 1, notice of such intent and  
9 information on the service area and plan type  
10 for each plan; and

11                      “(B) by July 1—

12                               “(i) the information described in para-  
13 graph (2) for the type of plan involved;  
14 and

15                               “(ii) the enrollment capacity (if any)  
16 in relation to the plan and area.

17               “(2) INFORMATION REQUIRED FOR COMPETI-  
18 TIVE PLANS.—The information described in this  
19 paragraph, which shall be submitted separately for  
20 combined part A and part B benefits, and for part  
21 D benefits, is as follows:

22                               “(A) The monthly plan bid for the provi-  
23 sion of benefits.

24                               “(B) The actuarial value of the reduction  
25 in cost-sharing for Medicare benefits included

1 in each plan bid (which value shall not exceed  
2 15 percent of the value of the balance of the  
3 bid).

4 “(C) A description of the cost-sharing for  
5 Medicare benefits that will apply and the actu-  
6 arial value of such cost-sharing.

7 “(D) For each supplemental benefits pack-  
8 age offered (if any), the adjusted community  
9 rate of the package, the monthly supplemental  
10 premium, a description of cost-sharing and such  
11 other information as the Secretary considers  
12 necessary.

13 “(E) The assumptions used with respect to  
14 numbers, in each payment area, of—

15 “(i) enrolled individuals who are aged  
16 or disabled; and

17 “(ii) enrolled individuals who have  
18 end-stage renal disease.”.

19 (B) CONFORMING AMENDMENTS.—

20 (i) Paragraphs (3) and (5) of section  
21 1854(a) are relocated and redesignated as  
22 paragraphs (3) and (4), respectively, of  
23 section 1853(c), as amended.

1 (ii) Section 1853(c)(3)(B) (42 U.S.C.  
2 1395w-23(c)(3)(B)), as redesignated, is  
3 amended by striking “beneficiary”.

4 (iii) Section 1853(c)(4)(B) (42 U.S.C.  
5 1395w-23(c)(3)(B)), as redesignated, is  
6 amended by striking “or subparagraphs  
7 (A)(ii) and (B) of paragraph (4)”.

8 (4) SECRETARY’S DETERMINATION OF PAY-  
9 MENT AMOUNT.—Section 1853 is further  
10 amended—

11 (A) by redesignating subsections (d)  
12 through (h) as subsections (e) through (i), re-  
13 spectively; and

14 (B) by adding after subsection (c) the fol-  
15 lowing new subsection:

16 “(d) SECRETARY’S DETERMINATION OF PAYMENT  
17 AMOUNT.—

18 “(1) CONVERSION TO NORMALIZED BIDS.—

19 “(A) NORMALIZED BIDS.—Subject to sub-  
20 paragraph (B), the Secretary shall adjust each  
21 monthly plan bid submitted under subsection  
22 (c) for the relative risk of enrollees in such plan  
23 based on health status and demographic adjust-  
24 ment factors.

1           “(B) SPECIAL RULE FOR PLAN BIDS FOR  
2 PART D BENEFITS BEFORE 2005.—The Sec-  
3 retary is not required, for years before 2005, to  
4 make the adjustments described in subpara-  
5 graph (A) with respect to plans for part D ben-  
6 efits.

7           “(2) COMPARISON TO PLAN BENCHMARK  
8 AMOUNT.—

9           “(A) DETERMINATION OF PLAN BENCH-  
10 MARK.—The Secretary shall determine, using  
11 the plan enrollment assumptions included in the  
12 organization’s bid, a plan benchmark amount  
13 for each plan equal to—

14           “(i) (until such time as the Secretary  
15 establishes an integrated risk adjustment  
16 system for individuals who are aged or dis-  
17 abled and for individuals who have end-  
18 stage renal disease)—

19           “(I) the product of the weighted  
20 average of the benchmark amounts for  
21 the payment areas included in the  
22 plan’s service area for individuals who  
23 are aged or disabled and the number  
24 of such individuals in the plan, plus

1                   “(II) the product of the weighted  
2                   average of the benchmark amounts for  
3                   the payment areas included in the  
4                   plan’s service area for individuals who  
5                   have end-stage renal disease and the  
6                   number of such individuals in the  
7                   plan, divided by the total number of  
8                   individuals in subclauses (I) and (II);  
9                   and

10                   “(ii) (after such time) the weighted  
11                   average of the benchmark amounts for the  
12                   payment areas included in the plan’s serv-  
13                   ice area.

14                   “(B) COMPARISON TO BENCHMARK; DE-  
15                   TERMINATION OF PAYMENT AMOUNT.—The  
16                   monthly payment to a Medicare+Choice organi-  
17                   zation with respect to each individual enrolled  
18                   in a plan shall be set as follows:

19                   “(i) IF BID DOES NOT EXCEED  
20                   BENCHMARK.—If the normalized bid deter-  
21                   mined under paragraph (1) does not ex-  
22                   ceed the plan benchmark amount deter-  
23                   mined under subparagraph (A), the month-  
24                   ly payment shall be the normalized bid, ad-  
25                   justed to account for the health status and

1 demographic adjustment factors of the in-  
 2 dividual enrollee.

3 “(ii) IF BID EXCEEDS BENCHMARK.—

4 If the normalized bid determined under  
 5 paragraph (1) exceeds the plan benchmark  
 6 amount determined under subparagraph  
 7 (B), the monthly payment shall be the nor-  
 8 malized bid, adjusted as described in  
 9 clause (i), minus the monthly excess pre-  
 10 mium determined under section 1854.”.

11 (b) PREMIUMS.—

12 (1) DETERMINATION OF PREMIUM AMOUNT.—

13 Section 1854 (42 U.S.C. 1395–4) is amended—

14 (A) by striking subsection (a) and redesign-  
 15 ating subsections (b) and (c) as subsections  
 16 (a) and (b);

17 (B) by adding after subsection (b) the fol-  
 18 lowing new subsection:

19 “(c) DETERMINATION OF MEDICARE PREMIUM RE-  
 20 Duction AND EXCESS PREMIUM.—

21 “(1) IN GENERAL.—Subject to paragraph (2),  
 22 the Secretary shall subtract the normalized bid (de-  
 23 termined under section 1853(d)(1)) from the plan’s  
 24 benchmark amount (determined under section  
 25 1853(d)(2)) to determine the Medicare premium re-

1       duction or monthly excess premium for plan enroll-  
 2       ees.

3               “(2) ADJUSTMENT.—If the difference between  
 4       the normalized bid and the plan’s benchmark  
 5       amount—

6                       “(A) is a positive amount, 75 percent of  
 7       that amount shall be equal to—

8                               “(i) the monthly Medicare premium  
 9                               reduction for individuals enrolled in the  
 10                              plan (up to the entire amount of the pre-  
 11                              mium for part B or part D, as applicable);  
 12                              and

13                             “(ii) the remainder, if any, under  
 14                             clause (i) shall be equal to the additional  
 15                             reduction in the actuarial value of plan  
 16                             cost-sharing for plan enrollees;

17                           “(B) is a negative amount, the absolute  
 18       value of that amount shall equal the monthly  
 19       excess premium for individuals enrolled in the  
 20       plan.

21       (2) LIMITATION ON ENROLLEE LIABILITY.—

22                       (A) FOR BASIC BENEFITS.—Section  
 23       1854(e)(1) (42 U.S.C. 1395w-4(e)(1)) is  
 24       amended to read as follows:

25                       “(1) FOR BASIC BENEFITS.—The sum of—

1           “(A) the actuarial value of the deductibles,  
2           coinsurance, and copayments applicable on av-  
3           erage to individuals enrolled under this part  
4           with a Medicare+Choice plan described in sec-  
5           tion 1851(a)(2)(A) or (C) of an organization  
6           with respect to benefits described in section  
7           1852(a)(1);

8           “(B) the reduction in cost sharing included  
9           in the plan bid;

10           “(C) the portion, if any, of the monthly  
11           supplemental premium that is in lieu of plan  
12           cost-sharing for Medicare benefits; and

13           “(D) any additional reduction in cost-shar-  
14           ing under subsection (c)(2)(A) (determined sep-  
15           arately with respect to benefits under parts A  
16           and B, and benefits under part D) must equal  
17           the actuarial value of the deductibles, coinsur-  
18           ance, and copayments that would be applicable  
19           on average to individuals entitled to such bene-  
20           fits if they were not members of a  
21           Medicare+Choice organization for the year (ad-  
22           justed as determined appropriate by the Sec-  
23           retary to account for geographic differences and  
24           for plan cost and utilization differences).”.

1 (B) FOR SUPPLEMENTAL BENEFITS.—  
2 Section 1854(e)(2) (42 U.S.C. 1395w-4(e)(2))  
3 is amended—

4 (i) by striking “section  
5 1851(a)(2)(A)” and inserting “subpara-  
6 graph (A) or (C) of section 1851(a)(2)”;

7 (ii) by striking “(multiplied by 12)”;  
8 and

9 (iii) by striking “may not exceed” and  
10 inserting “must equal”.

11 (c) OTHER CHANGES IN PLAN DESIGN.—

12 (1) ALLOWING PLANS TO INCLUDE COST SHAR-  
13 ING REDUCTION IN THEIR BASIC BENEFITS.—Sec-  
14 tion 1852(a)(1) (42 U.S.C. 1395w-22(a)(1)) is  
15 amended by striking subparagraph (B) and inserting  
16 the following—

17 “(B) at plan option, reduction in cost-shar-  
18 ing for part A and part B benefits, or part D  
19 benefits, that would otherwise be applicable (the  
20 actuarial value of such reduction however shall  
21 not exceed 15 percent of the value of the por-  
22 tion of the bid related to combined part A and  
23 part B benefits, or part D benefits, as applica-  
24 ble).”.

1           (2) ELIMINATION OF MANDATORY SUPPLE-  
2           MENTAL BENEFITS.—Section 1852(a)(3) (42 U.S.C.  
3           1395w–22(a)(3)) is amended by striking subpara-  
4           graph (A) and redesignating subparagraphs (B) and  
5           (C) and subparagraphs (A) and (B).

6           (d) CONFORMING AMENDMENTS.—

7           (1) PREMIUM REDUCTIONS.—

8           (A) UNDER PART B.—

9           (i) Section 1839(a)(2) (42 U.S.C.  
10           1395r(a)(2)) is amended by striking  
11           “shall” and all that follows and inserting  
12           “shall be the amount determined under  
13           paragraph (3), adjusted as required in ac-  
14           cordance with subsections (b), (c), and (f),  
15           and thereafter further modified as required  
16           to comply with section 1854(c)(2)(A).”.

17           (ii) Section 1840 (42 U.S.C. 1395s) is  
18           amended by adding at the end the fol-  
19           lowing:

20           “(i) The Secretary shall provide for  
21           necessary adjustments of the Medicare pre-  
22           mium for Medicare+Choice enrollees de-  
23           termined under section 1854(c)(2)(A).  
24           This premium adjustment may be provided  
25           directly or as an adjustment to Social Se-

1 security, Railroad Retirement and Civil Serv-  
2 ice Retirement benefits, as appropriate, as  
3 the Secretary determines feasible with the  
4 concurrence of such agencies.”.

5 (B) UNDER PART D.—

6 (i) Section 1859D(a)(2)(B) is amend-  
7 ed by inserting “thereafter further modi-  
8 fied as required to comply with section  
9 1854(c)(2)(A),” before “and rounded”.

10 (ii) Section 1859(b)(1) is amended by  
11 adding at the end the following:

12 “(C) The Secretary shall provide for nec-  
13 essary adjustments of the Medicare premium  
14 for Medicare+Choice enrollees determined  
15 under section 1854(c)(2)(A). This premium ad-  
16 justment may be provided directly or as an ad-  
17 justment to Social Security, Railroad Retire-  
18 ment and Civil Service Retirement benefits, as  
19 appropriate, as the Secretary determines fea-  
20 sible with the concurrence of such agencies.”.

21 (2) APPROPRIATIONS FOR GOVERNMENT CON-  
22 TRIBUTION.—Section 1844(a)(1) (42 U.S.C.  
23 1395w(a)(1)) is amended by adding after subpara-  
24 graph (B) the following new subparagraph:

1           “(C) an adjustment for the Government  
2           contribution to reflect the savings to the Trust  
3           Fund from enrollment in Medicare+Choice  
4           plans by beneficiaries who receive monthly  
5           Medicare premium reductions in accordance  
6           with section 1854(c)(2)(A).”.

7           (3) Section 1851(b)(1)(B) (42 U.S.C. 1395w-  
8           21(b)(1)(B)) is amended by striking “section  
9           1852(a)(1)(A)” and inserting “section 1852(a)(1)”.

10          (4) Section 1851(d)(2)(A) (42 U.S.C. 1395w-  
11          21(d)(2)(A)) is amended by striking “At least 15  
12          days before” and inserting “Before”.

13          (5) Part C is amended by striking “BENE-  
14          FICLARY” each time it appears immediately before  
15          “PREMIUM” or “PREMIUMS”, and by striking “bene-  
16          ficiary” each time it appears immediately before  
17          “premium” or “premiums”.

18          (6) Section 1851(d)(4)(B) (42 U.S.C. 1395w-  
19          21(d)(4)(B)) is amended—

20                 (A) by inserting “(i)” after “PREMI-  
21                 UMS.—”; and

22                 (B) by adding before the period “; and (ii)  
23                 the reduction in the part B and part D pre-  
24                 miums, if any”.

1           (7) Section 1851(d)(4)(E) (42 U.S.C. 1395w–  
2           21(d)(4)(E)) is amended by striking “includes man-  
3           datory supplemental benefits in its base benefit  
4           package or”.

5           (8) Section 1852(a)(5) (42 U.S.C. 1395w–  
6           22(a)(5)) is amended by striking “the annual  
7           Medicare+Choice capitation rate” and inserting  
8           “the national monthly per capita costs”.

9           (9) Section 1852(c)(1)(F) (42 U.S.C. 1395w–  
10          22(c)(1)(F)) is amended by striking clause (i) and  
11          redesignating clauses (ii) and (iii) as clauses (i) and  
12          (ii).

13          (10) Section 1853(a)(1)(B) (42 U.S.C. 1395w–  
14          23(a)(1)(B)) is amended by striking the first and  
15          second sentences.

16          (11) Section 1853(e)(3)(B) (42 U.S.C. 1395w–  
17          23(e)(3)(B)), as redesignated, is amended—

18                 (A) in the caption, by striking “BUDGET  
19                 NEUTRALITY”;

20                 (B) by striking “adjust the payment rates”  
21                 and all that follows through “that would have  
22                 been made” and inserting “adjust the bench-  
23                 mark amounts otherwise established under this  
24                 section for Medicare+Choice payment areas in  
25                 the State in a manner so that the weighted av-

1           erage of the benchmark amounts under this  
2           section in the State equals the weighted average  
3           of benchmark amounts that would have been  
4           applicable”.

5           (12) Section 1853(i)(2) (42 U.S.C. 1395w-  
6           23(i)(2)), as redesignated, is amended—

7                   (A) by inserting “and” at the end of sub-  
8           paragraph (A);

9                   (B) by striking “; and” at the end of sub-  
10          paragraph (B) and inserting a period; and

11                   (C) by striking subparagraph (C).

12           (13)(A) Section 1854(a)(2)(A) (42 U.S.C.  
13          1395w-4(a)(2)(A)), as redesignated, is amended by  
14          striking “the amount authorized to be charged” and  
15          all that follows and inserting “the amount required  
16          to be charged under subsection (c)(2)(B) for the  
17          plan.”.

18           (B) Section 1854(a)(2)(B) (42 U.S.C. 1395w-  
19          4(a)(2)(B)), as redesignated, is amended—

20                   (i) by striking “or Medicare+Choice fee-  
21          for-service plan”, and

22                   (ii) by striking “or (4)(B)”.

23           (14) Section 1854(e) (42 U.S.C. 1395w-4(e)) is  
24          amended by striking paragraph (4).

1           (15)(A) Paragraphs (3) and (4) of section  
2           1854(f) (42 U.S.C. 1395w-4(f)) are relocated and  
3           redesignated as paragraphs (4) and (5) of subsection  
4           (e).

5           (B) Section 1854(e)(4) (42 U.S.C. 1395w-  
6           4(e)(4)), as so redesignated, is amended by striking  
7           “subject to paragraph (4)” and inserting “subject to  
8           paragraph (5)”.

9           (C) Section 1854(f) (42 U.S.C. 1395w-4(f)) is  
10          stricken.

11          (16) Section 1858(c), as redesignated by section  
12          201, is amended by striking paragraph (3) and re-  
13          designating paragraph (4) as paragraph (3).

14          (e) EFFECTIVE DATE.—The amendments made by  
15          this section shall be effective for 2003 and succeeding  
16          years.

17          **PART B—PRIVATE SECTOR PURCHASING AND**  
18          **QUALITY IMPROVEMENT TOOLS FOR ORIGI-**  
19          **NAL MEDICARE**

20          **SEC. 111. CARE COORDINATION SERVICES.**

21          (a) PROGRAM AUTHORIZED.—Title XVIII (42 U.S.C.  
22          1395 et seq.) is amended by adding after section 1866  
23          the following new section:

24          **“SEC. 1866A. CARE COORDINATION SERVICES.**

25          “(a) IN GENERAL.—

1           “(1) PROGRAM AUTHORITY.—The Secretary,  
2           beginning in 2002, may implement a care coordina-  
3           tion services program in accordance with the provi-  
4           sions of this section under which, in appropriate cir-  
5           cumstances, eligible individuals may elect to have  
6           health care services covered under this title managed  
7           and coordinated by a designated care coordinator.

8           “(2) ADMINISTRATION BY CONTRACT.—Except  
9           as otherwise specifically provided, the Secretary may  
10          administer the program under this section in accord-  
11          ance with section 1866M.

12          “(b) ELIGIBILITY CRITERIA; IDENTIFICATION AND  
13          NOTIFICATION OF ELIGIBLE INDIVIDUALS.—

14                 “(1) INDIVIDUAL ELIGIBILITY CRITERIA.—The  
15                 Secretary shall specify criteria to be used in making  
16                 a determination as to whether an individual may ap-  
17                 propriately be enrolled in the care coordination serv-  
18                 ices program under this section, which shall include  
19                 at least a finding by the Secretary that for cohorts  
20                 of individuals with characteristics identified by the  
21                 Secretary, professional management and coordina-  
22                 tion of care can reasonably be expected to improve  
23                 processes or outcomes of health care and to reduce  
24                 aggregate costs to the programs under this title.

1           “(2) PROCEDURES TO FACILITATE ENROLL-  
2           MENT.—The Secretary shall develop and implement  
3           procedures designed to facilitate enrollment of eligi-  
4           ble individuals in the program under this section.

5           “(c) ENROLLMENT OF INDIVIDUALS.—

6           “(1) SECRETARY’S DETERMINATION OF ELIGI-  
7           BILITY.—The Secretary shall determine the eligi-  
8           bility for services under this section of individuals  
9           who are enrolled in the program under this section  
10          and who make application for such services in such  
11          form and manner as the Secretary may prescribe.

12          “(2) ENROLLMENT PERIOD.—

13          “(A) EFFECTIVE DATE AND DURATION.—  
14          Enrollment of an individual in the program  
15          under this section shall be effective as of the  
16          first day of the month following the month in  
17          which the Secretary approves the individual’s  
18          application under paragraph (1), shall remain  
19          in effect for one month (or such longer period  
20          as the Secretary may specify), and shall be  
21          automatically renewed for additional periods,  
22          unless terminated in accordance with such pro-  
23          cedures as the Secretary shall establish by regu-  
24          lation.

1           “(B) LIMITATION ON REENROLLMENT.—  
2           The Secretary may establish limits on an indi-  
3           vidual’s eligibility to reenroll in the program  
4           under this section if the individual has  
5           disenrolled from the program more than once  
6           during a specified time period.

7           “(d) PROGRAM.—The care coordination services pro-  
8           gram under this section shall include the following ele-  
9           ments:

10           “(1) BASIC CARE COORDINATION SERVICES.—

11           “(A) IN GENERAL.—Subject to the cost-ef-  
12           fectiveness criteria specified in subsection  
13           (b)(1), except as otherwise provided in this sec-  
14           tion, enrolled individuals shall receive services  
15           described in section 1905(t)(1) and may receive  
16           additional items and services as described in  
17           subparagraph (B).

18           “(B) ADDITIONAL BENEFITS.—The Sec-  
19           retary may specify additional benefits for which  
20           payment would not otherwise be made under  
21           this title that may be available to individuals  
22           enrolled in the program under this section (sub-  
23           ject to an assessment by the care coordinator of  
24           an individual’s circumstance and need for such

1           benefits) in order to encourage enrollment in, or  
2           to improve the effectiveness of, such program.

3           “(2) CARE COORDINATION REQUIREMENT.—

4           Notwithstanding any other provision of this title, the  
5           Secretary may provide that an individual enrolled in  
6           the program under this section may be entitled to  
7           payment under this title for any specified health  
8           care items or services only if the items or services  
9           have been furnished by the care coordinator, or co-  
10          ordinated through the care coordination services pro-  
11          gram. Under such provision, the Secretary shall pre-  
12          scribe exceptions for emergency medical services as  
13          described in section 1852(d)(3), and other excep-  
14          tions determined by the Secretary for the delivery of  
15          timely and needed care.

16          “(3) REDUCTION OR ELIMINATION OF COST  
17          SHARING.—Notwithstanding any other provision of  
18          law, subject to the cost-effectiveness criteria speci-  
19          fied in subsection (b)(1), the Secretary may provide  
20          for the reduction or elimination of beneficiary cost  
21          sharing (such as deductibles, copayments, and coin-  
22          surance) with respect to any of the items or services  
23          furnished under this title (other than the care co-  
24          ordination services and other benefits described in

1 paragraph (1)) and may limit such reduction or  
2 elimination to particular service areas.

3 “(e) CARE COORDINATORS.—

4 “(1) CONDITIONS OF PARTICIPATION.—In order  
5 to be qualified to furnish care coordination services  
6 under this section, an individual or entity shall—

7 “(A) be a health care professional or entity  
8 (which may include physicians, physician group  
9 practices, or other health care professionals or  
10 entities the Secretary may find appropriate)  
11 meeting such conditions as the Secretary may  
12 specify;

13 “(B) have entered into a care coordination  
14 agreement; and

15 “(C) meet such criteria as the Secretary  
16 may establish (which may include experience in  
17 the provision of care coordination or primary  
18 care physician’s services).

19 “(2) AGREEMENT TERM; PAYMENT.—

20 “(A) DURATION AND RENEWAL.—A care  
21 coordination agreement under this subsection  
22 shall be for one year and may be renewed if the  
23 Secretary is satisfied that the care coordinator  
24 continues to meet the conditions of participa-  
25 tion specified in paragraph (1).

1           “(B) PAYMENT FOR SERVICES.—The Sec-  
 2           retary may negotiate or otherwise establish pay-  
 3           ment terms and rates for services described in  
 4           subsection (d)(1).

5           “(C) TERMS.—In addition to such other  
 6           terms as the Secretary may require, an agree-  
 7           ment under this section shall include the terms  
 8           specified in subparagraphs (A) through (C) of  
 9           section 1905(t)(3).”.

10       (b) COVERAGE OF CARE COORDINATION SERVICES  
 11 AS A PART B MEDICAL SERVICE.—

12       (1) IN GENERAL.—Section 1861(s) (42 U.S.C.  
 13       1395x(s)) is amended—

14           (A) in the second sentence, by redesign-  
 15           ating paragraphs (16) and (17) as clauses (i)  
 16           and (ii); and

17           (B) in the first sentence—

18               (i) by striking “and” at the end of  
 19               paragraph (14);

20               (ii) by striking the period at the end  
 21               of paragraph (15) and inserting “; and”;  
 22               and

23               (iii) by adding after paragraph (15)  
 24               the following new paragraph:

1           “(16) care coordination services furnished in  
2 accordance with section 1866A.”.

3           (2) PART B COINSURANCE AND DEDUCTIBLE  
4 NOT APPLICABLE TO CARE COORDINATION SERV-  
5 ICES.—

6           (A) COINSURANCE.—Section 1833(a)(1) is  
7 amended—

8           (i) by striking “and” at the end of  
9 subparagraph (R); and

10           (ii) by inserting before the final semi-  
11 colon “, and (T) with respect to care co-  
12 ordination services described in section  
13 1861(s)(16), the amounts paid shall be  
14 100 percent of the payment amount estab-  
15 lished under section 1866C”.

16           (B) DEDUCTIBLE.—Section 1833(b) (42  
17 U.S.C. 1395l(b)) is amended—

18           (i) by striking “and” at the end of  
19 paragraph (5); and

20           (ii) by inserting before the final period  
21 “, and (7) such deductible shall not apply  
22 with respect to care coordination services  
23 (as described in section 1861(s)(16))”.

1 **SEC. 112. DISEASE MANAGEMENT SERVICES.**

2 (a) PROGRAM AUTHORIZED.—Title XVIII (42 U.S.C.  
3 1395 et seq.), as previously amended by this part, is fur-  
4 ther amended by adding after section 1866A the following  
5 new section:

6 **“SEC. 1866B. DISEASE MANAGEMENT SERVICES.**

7 “(a) IN GENERAL.—

8 “(1) PROGRAM AUTHORITY.—The Secretary,  
9 beginning in 2002, may implement a program in ac-  
10 cordance with the provisions of this section under  
11 which certain eligible individuals may, in appropriate  
12 circumstances, receive disease management services  
13 from entities designated by the Secretary with re-  
14 spect to diagnoses that the Secretary determines are  
15 amenable to such management.

16 “(2) ADMINISTRATION BY CONTRACT.—Except  
17 as otherwise specifically provided, the Secretary may  
18 administer the program under this section in accord-  
19 ance with section 1866M.

20 “(b) INDIVIDUALS WHO MAY RECEIVE DISEASE  
21 MANAGEMENT SERVICES.—No individual shall be eligible  
22 for enrollment in a disease management program under  
23 this section unless the Secretary finds the following with  
24 respect to the individual:

25 “(1) DIAGNOSIS AND RELATED CHARACTERIS-  
26 TICS.—

1           “(A) IN GENERAL.—The individual has  
2           been diagnosed with congestive heart failure,  
3           chronic obstructive pulmonary disease, diabetes,  
4           or any other diagnosis, if the Secretary has de-  
5           termined with respect to such diagnoses that  
6           there is evidence that the provision of disease  
7           management services, over clinically relevant  
8           time-periods, to cohorts of individuals with such  
9           diagnoses can reasonably be expected to im-  
10          prove processes or outcomes of health care for  
11          the Medicare population and to reduce aggre-  
12          gate costs to the programs under this title.

13           “(B) ADDITIONAL FACTORS.—Where re-  
14          quired by the Secretary, the individual also has  
15          certain clinical characteristics or conditions, ex-  
16          hibits certain patterns of utilization, or mani-  
17          fests other factors indicating the need for and  
18          potential effectiveness of disease management.

19           “(2) REFERRAL BY QUALIFIED INDIVIDUAL OR  
20          ENTITY.—The individual has been referred for con-  
21          sideration for such services by an individual or entity  
22          furnishing health care items or services, or by an en-  
23          tity administering benefits under this title.

24           “(c) PROCEDURES TO FACILITATE ENROLLMENT.—  
25          The Secretary shall develop and implement procedures de-

1 signed to facilitate enrollment of eligible individuals in the  
2 program under this section.

3 “(d) ENROLLMENT OF INDIVIDUALS WITH DISEASE  
4 MANAGEMENT ORGANIZATIONS.—

5 “(1) EFFECTIVE DATE AND DURATION.—En-  
6 rollment of an individual in the program under this  
7 section shall remain in effect for one month (or such  
8 longer period as the Secretary may specify), and  
9 shall be automatically renewed for additional peri-  
10 ods, unless terminated in accordance with such pro-  
11 cedures as the Secretary shall establish by regula-  
12 tion.

13 “(2) LIMITATION ON REENROLLMENT.—The  
14 Secretary may establish limits on an individual’s eli-  
15 gibility to reenroll in the program under this section  
16 if the individual has disenrolled from the program  
17 more than once during a specified time period.

18 “(e) DISEASE MANAGEMENT REQUIREMENT.—Not-  
19 withstanding any other provision of this title, the Sec-  
20 retary may provide that an individual enrolled in the pro-  
21 gram under this section may be entitled to payment under  
22 this title for any specified health care items or services  
23 only if the items or services have been furnished by the  
24 disease management organization, or coordinated through  
25 the disease management services program. Under such

1 provision, the Secretary shall prescribe exceptions for  
2 emergency medical services as described in section  
3 1852(d)(3), and other exceptions determined by the Sec-  
4 retary for the delivery of timely and needed care.

5 “(f) DISEASE MANAGEMENT SERVICES.—

6 “(1) IN GENERAL.—Subject to the cost-effec-  
7 tiveness criteria specified in subsection (b)(1), dis-  
8 ease management services provided to an individual  
9 under this section may include—

10 “(A) initial and periodic health screening  
11 and assessment;

12 “(B) management (including coordination  
13 with other providers) of, and referral for, med-  
14 ical and other health services related to the  
15 managed diagnosis (which may include referral  
16 for provision of such services by the disease  
17 management organization);

18 “(C) monitoring and control of medications  
19 (including coordination with the entity man-  
20 aging benefits for the individual under part D);

21 “(D) patient education and counseling;

22 “(E) nursing or other health professional  
23 home visits, as appropriate;

24 “(F) providing access for consultations by  
25 telephone with physicians or other appropriate

1 medical professionals, including 24-hour avail-  
2 ability for emergency consultations;

3 “(G) managing and facilitating the transi-  
4 tion to other care arrangements in preparation  
5 for termination of the disease management en-  
6 rollment; and

7 “(H) such other services for which pay-  
8 ment would not otherwise be made under this  
9 title as the Secretary shall determine to be ap-  
10 propriate.

11 “(2) VARIATIONS IN SERVICE PACKAGES.—The  
12 types and combinations of disease management serv-  
13 ices furnished under agreements under this section  
14 may vary (as permitted or required by the Sec-  
15 retary) according to the types of diagnoses, condi-  
16 tions, patient profiles being managed, expertise of  
17 the disease management organization, and other fac-  
18 tors the Secretary finds appropriate.

19 “(3) REDUCTION OR ELIMINATION OF COST  
20 SHARING.—Notwithstanding any other provision of  
21 law, subject to the cost-effectiveness criteria speci-  
22 fied in subsection (b)(1), the Secretary may provide  
23 for the reduction or elimination of beneficiary cost  
24 sharing (such as deductibles, copayments, and coin-  
25 surance) with respect to any of the items or services

1 furnished under this title (other than those fur-  
2 nished under a service package developed under  
3 paragraph (2)), and may limit such reduction or  
4 elimination to particular service areas.

5 “(g) AGREEMENTS WITH DISEASE MANAGEMENT  
6 ORGANIZATIONS.—

7 “(1) ENTITIES ELIGIBLE.—Entities qualified to  
8 enter into agreements with the Secretary for the  
9 provision of disease management services under this  
10 section include entities that have demonstrated the  
11 ability to meet the performance standards and other  
12 criteria established by the Secretary with respect  
13 to—

14 “(A) the management of each diagnosis  
15 and condition with respect to which the entity,  
16 if designated, would furnish disease manage-  
17 ment services under this section; and

18 “(B) the implementation of each disease  
19 management approach that the entity, if des-  
20 ignated, would implement under this section.

21 “(2) CONDITIONS OF PARTICIPATION.—In order  
22 to be eligible to provide disease management services  
23 under this section, an entity shall—

24 “(A) have in effect an agreement with the  
25 Secretary setting forth such obligations of the

1           entity as a disease management organization  
2           under this section as the Secretary shall pre-  
3           scribe;

4                   “(B) meet the standards established by the  
5           Secretary under subsection (h); and

6                   “(C) meet such other conditions as the  
7           Secretary may establish.

8           “(3) SECRETARY’S OPTION FOR NONCOMPETI-  
9           TIVE DESIGNATION.—The Secretary may designate  
10          an entity to provide disease management services  
11          under this section without regard to the require-  
12          ments of section 5 of title 41, United States Code.

13          “(h) STANDARDS.—

14                   “(1) QUALITY.—The Secretary shall establish  
15          standards for, and procedures for assessing, the  
16          quality of care provided by disease management or-  
17          ganizations under this section, which shall include—

18                           “(A) performance standards with respect  
19                           to the processes or outcomes of health care or  
20                           the health status of enrolled individuals, includ-  
21                           ing procedures for establishing a baseline and  
22                           measuring changes in health care processes or  
23                           health outcomes with respect to managed dis-  
24                           eases or health conditions;

1           “(B) a requirement that the organization  
2           meet such licensure and other accreditation  
3           standards as the Secretary may find appro-  
4           priate; and

5           “(C) such other quality standards, includ-  
6           ing patient satisfaction, as the Secretary may  
7           find appropriate.

8           “(2) COST MANAGEMENT.—The Secretary shall  
9           establish a performance standard with respect to  
10          management or reduction of the aggregate costs of  
11          health care items and services related to managed  
12          health conditions furnished to enrolled individuals,  
13          including procedures for establishing a baseline and  
14          measuring changes in costs for such items and serv-  
15          ices.

16          “(i) PAYMENT.—

17                 “(1) TERMS OF PAYMENT.—The Secretary may  
18                 negotiate or otherwise establish payment terms and  
19                 rates for service packages developed under sub-  
20                 section (f)(2).

21                 “(2) WITHHOLDING OF PAYMENTS.—An agree-  
22                 ment under subsection (g) may provide that the Sec-  
23                 retary may withhold up to ten percent of the amount  
24                 due a disease management organization under the  
25                 basis of payment established under paragraph (1)

1       until such time as such organization meets a stand-  
2       ard or standards specified in such agreement.

3       (b) COVERAGE OF DISEASE MANAGEMENT SERVICES  
4 AS A PART B MEDICAL SERVICE.—

5           (1) IN GENERAL.—Section 1861(s), as amended  
6       by section 111, is further amended—

7           (A) by striking “and” at the end of para-  
8       graph (15);

9           (B) by striking the period at the end of  
10       paragraph (16) and inserting “and”; and

11          (C) by adding after paragraph (16) the fol-  
12       lowing new paragraph:

13       “(17) disease management services furnished in  
14       accordance with section 1866B.”.

15          (2) PART B COINSURANCE AND DEDUCTIBLE  
16       NOT APPLICABLE TO DISEASE MANAGEMENT SERV-  
17       ICES.—

18           (A)                   COINSURANCE.—Section  
19       1833(a)(1)(T) (42 U.S.C. 1395l(a)(1)(T)), as  
20       added by section 111(b)(2)(A), is amended to  
21       read as follows: “(T) with respect to care co-  
22       ordination services described in section  
23       1861(s)(16) and disease management services  
24       described in section 1861(s)(17), the amounts  
25       paid shall be 100 percent of the payment

1 amounts established under sections 1866A and  
2 1866B, respectively.”

3 (B) DEDUCTIBLE.—Section 1833(b) (42  
4 U.S.C. 1395l(b)), as amended by section  
5 111(b)(2)(A), is further amended by inserting  
6 before the final period “or to disease manage-  
7 ment services (as described in section  
8 1861(s)(17))”.

9 **SEC. 113. COMPETITIVE ACQUISITION OF ITEMS AND SERV-**  
10 **ICES.**

11 (a) PROGRAM AUTHORIZED.—Title XVIII (42 U.S.C.  
12 1395 et seq.), as previously amended by this part, is fur-  
13 ther amended by adding after section 1866B the following  
14 new section:

15 **“SEC. 1866C. COMPETITIVE ACQUISITION OF ITEMS AND**  
16 **SERVICES.**

17 “(a) IN GENERAL.—

18 “(1) PROGRAM AUTHORITY.—The Secretary  
19 shall implement a program to purchase, on behalf of  
20 individuals enrolled under this part certain competi-  
21 tively priced items and services for which payment  
22 may be made under part B.

23 “(2) ADMINISTRATION BY CONTRACT.—Except  
24 as otherwise specifically provided, the Secretary may

1 administer the program under this section in accord-  
2 ance with section 1866M.

3 “(b) ESTABLISHMENT OF COMPETITIVE ACQUISI-  
4 TION AREAS.—

5 “(1) IN GENERAL.—The Secretary shall estab-  
6 lish competitive acquisition areas for agreement  
7 award purposes for the furnishing under part B of  
8 the items and services described in subsection (d)  
9 after 2002. The Secretary may establish different  
10 competitive acquisition areas under this subsection  
11 for different classes of items and services.

12 “(2) CRITERIA FOR ESTABLISHMENT.—The  
13 competitive acquisition areas established under para-  
14 graph (1) shall be chosen based on the availability  
15 and accessibility of individuals and entities able to  
16 furnish items and services, and the estimated sav-  
17 ings to be realized by the use of competitive acquisi-  
18 tion in the furnishing of items and services in the  
19 area.

20 “(c) AWARDING OF AGREEMENTS IN COMPETITIVE  
21 ACQUISITION AREAS.—

22 “(1) IN GENERAL.—The Secretary shall con-  
23 duct a competition among individuals and entities  
24 supplying items and services described in subsection  
25 (d) for each competitive acquisition area established

1 under subsection (b) for each class of items and  
2 services.

3 “(2) CONDITIONS FOR AWARDING AGREEMENT.—The Secretary may not enter an agreement  
4 with any entity under the competition conducted  
5 pursuant to paragraph (1) to furnish an item or  
6 service unless the Secretary finds that the entity  
7 meets quality standards specified by the Secretary,  
8 and that the aggregate amounts to be paid under  
9 the agreement are expected to be less than the ag-  
10 gregate amounts that would otherwise be paid.  
11

12 “(3) TERMS OF AGREEMENT.—An agree-  
13 ment entered into with an entity under the  
14 competition conducted pursuant to paragraph  
15 (1) is subject to terms and conditions that the  
16 Secretary may specify.

17 “(d) SERVICES DESCRIBED.—The items and services  
18 to which this section applies are all items and services de-  
19 scribed in paragraphs (3) and (5) through (9) of section  
20 1861(s) (other than custom fabricated prostheses, as de-  
21 fined by the Secretary), and such other items or services  
22 as the Secretary may specify.”.

23 (b) ITEMS AND SERVICES TO BE FURNISHED ONLY  
24 THROUGH COMPETITIVE ACQUISITION.—Section 1862(a)  
25 (42 U.S.C. 1395y(a)) is amended—

1           (1) by striking “or” at the end of paragraph  
2           (20),

3           (2) by striking the period at the end of para-  
4           graph (21) and inserting “; or”, and

5           (3) by adding after paragraph (21) the fol-  
6           lowing:

7           “(22) where the expenses are for an item or  
8           service furnished in a competitive acquisition area  
9           (as established by the Secretary under section  
10          1866C(a)) by an entity other than an entity with  
11          which the Secretary has entered into an agreement  
12          under section 1866C(e) for the furnishing of such an  
13          item or service in that area, except in such cases of  
14          emergency or urgent need as the Secretary shall pre-  
15          scribe.

16          (c) EFFECTIVE DATE.—The amendments made by  
17          subsections (a) and (b) apply to items and services fur-  
18          nished after 2002.

19          **SEC. 114. PROVIDER AND PHYSICIAN COLLABORATIONS.**

20          Title XVIII (42 U.S.C. 1395 et seq.), as previously  
21          amended by this part, is further amended by adding after  
22          section 1866C the following new section:

23          **“SEC. 1866D. PROVIDER AND PHYSICIAN COLLABORATIONS.**

24          “(a) IN GENERAL.—

1           “(1) PROGRAM AUTHORITY.—The Secretary  
2           may enter into agreements with specific providers,  
3           suppliers, or other individuals or entities for the fur-  
4           nishing of bundled items and services in selected  
5           sites of service or related to specific medical condi-  
6           tions or needs for an episode of care. The services  
7           may include any items or services covered under this  
8           title that the Secretary determines to be appropriate,  
9           including post-hospital services.

10           “(2) ADMINISTRATION BY CONTRACT.—Except  
11           as otherwise specifically provided, the Secretary may  
12           administer the program under this section in accord-  
13           ance with section 1866M.

14           “(b) BASIS OF SELECTION.—The Secretary shall se-  
15           lect entities for agreements under this section on the basis  
16           of ability to provide services more efficiently, to provide  
17           improved coordination of care, to offer additional benefits,  
18           and to meet quality and other standards and beneficiary  
19           protections and other requirements set by the Secretary.

20           “(c) PAYMENT.—Payment under this section shall be  
21           made on the basis of all-inclusive rates. The all-inclusive  
22           rate paid to an entity for bundled items and services fur-  
23           nished during an episode of care under this section shall  
24           be less than the estimated amount of the payments that

1 the Secretary would have otherwise made for the items  
2 and services.

3 “(d) **TERM OF AGREEMENT.**—Agreements under this  
4 section shall be for periods that the Secretary may deter-  
5 mine.

6 “(e) **INCENTIVES TO BENEFICIARIES FOR USE OF**  
7 **CONTRACTING ENTITIES.**—Notwithstanding any other  
8 provision of law, entities under a contract under this sec-  
9 tion may furnish additional services or waive part or all  
10 beneficiary cost sharing (such as deductibles, copayments,  
11 and coinsurance) with respect to any of the items or serv-  
12 ices furnished under this section.

13 “(f) **BENEFICIARY ELECTION.**—An individual enti-  
14 tled to benefits under this title who elects to obtain serv-  
15 ices under an agreement under this section shall agree to  
16 receive under such agreement all benefits related to the  
17 episode of care covered by the agreement (subject to such  
18 exceptions for emergency services and as the Secretary  
19 otherwise may specify).”.

20 **SEC. 115. PREFERRED PARTICIPANTS.**

21 (a) **IN GENERAL.**—Title XVIII (42 U.S.C. 1395 et  
22 seq.), as previously amended by this part, is further  
23 amended by adding after section 1866D the following new  
24 section:

1 **“SEC. 1866E. PREFERRED PARTICIPANTS.**

2 “(a) PROGRAM AUTHORITY.—

3 “(1) IN GENERAL.—The Secretary shall imple-  
4 ment beginning in 2002, a preferred participant pro-  
5 gram, under which the Secretary enters into agree-  
6 ments for the furnishing of health care items and  
7 services by individuals and entities participating in  
8 the program under part A or B of this title that pro-  
9 vide high-quality, efficient health care.

10 “(2) LIMITATION.—The Secretary shall not im-  
11 plement the program under this section with respect  
12 to a service area, or with respect to a category of in-  
13 dividuals and entities furnishing items and services  
14 in such service area, unless the Secretary estimates  
15 that to do so will reduce the cost and improve the  
16 quality of the programs under this title.

17 “(3) ADMINISTRATION BY CONTRACT.—Except  
18 as otherwise specifically provided, the Secretary shall  
19 administer the program under this section in accord-  
20 ance with section 1866M.

21 “(b) PREFERRED PARTICIPANT AGREEMENT.—

22 “(1) CRITERIA AND TERMS.—In order to be eli-  
23 gible to participate in the program under part A or  
24 B as a preferred participant, an individual or entity  
25 shall meet the following conditions:

1           “(A) PARTICIPATION CRITERIA.—The indi-  
2           vidual or entity shall meet the criteria estab-  
3           lished by the Secretary under section  
4           1866M(b)(5) (relating to quality, cost-effective-  
5           ness, categories of participants in service area,  
6           and such other standards or criteria as the Sec-  
7           retary may establish).

8           “(B) PAYMENT RATE.—The individual or  
9           entity shall agree to accept payment, for cov-  
10          ered health care items and services furnished  
11          during the term of the agreement, at the rates  
12          established under this section (which may in-  
13          clude rates in effect under part A or B, dis-  
14          counted rates, or such other rates as the Sec-  
15          retary may find appropriate).

16          “(2) DURATION.—A preferred participant agreement  
17          under this section shall be for a calendar year (or,  
18          in the case of an agreement commencing after the  
19          first day of January (or such later date as the Sec-  
20          retary may specify), for the remainder of such cal-  
21          endar year), and shall be annually renewable, at the  
22          option of the participant, while the participant con-  
23          tinues to meet all applicable conditions of participa-  
24          tion.

1       “(c) OPTION TO REDUCE COST SHARING.—Notwith-  
2 standing any other provision of law, subject to the cost-  
3 effectiveness criteria specified in subsection (a)(2), the  
4 Secretary may—

5           “(1) provide for the reduction or elimination of  
6 beneficiary cost sharing (such as deductibles, copay-  
7 ments, and coinsurance) with respect to any of the  
8 items or services furnished under this section, and  
9 may limit such reduction or elimination to particular  
10 service areas; and

11           “(2) permit individuals or entities under an  
12 agreement under this section to waive part or all of  
13 such beneficiary cost sharing.”.

14       (b) DEFINITIONS.—Section 1861 (42 U.S.C. 1395x)  
15 is amended by adding at the end the following new sub-  
16 section:

17           “(uu) PREFERRED PARTICIPANT.—The term ‘pre-  
18 ferred participant’ means an individual or entity that fur-  
19 nishes health care items or services under part A or B  
20 and that has in effect an agreement under section  
21 1866E(b).”.

22 **SEC. 116. CENTERS OF EXCELLENCE.**

23       Title XVIII (42 U.S.C. 1395 et seq.), as previously  
24 amended by this part, is further amended by adding after  
25 section 1866E the following new section:

1 **“SEC. 1866F. CENTERS OF EXCELLENCE.**

2 “(a) IN GENERAL.—

3 “(1) COMPETITION TO FURNISH BUNDLED  
4 ITEMS AND SERVICES.—The Secretary, beginning in  
5 2002, shall use a competitive process to enter into  
6 agreements with specific hospitals or other entities  
7 for the furnishing of bundled groups of items and  
8 services related to certain surgical procedures, and  
9 of other bundled groups of items and services (unre-  
10 lated to surgical procedures) specified by the Sec-  
11 retary furnished during an episode of care (as de-  
12 fined by the Secretary). Such items and services may  
13 include any items or services covered under this title  
14 that the Secretary determines to be appropriate.

15 “(2) ADMINISTRATION BY CONTRACT.—Except  
16 as otherwise specifically provided, the Secretary may  
17 administer the program under this section in accord-  
18 ance with section 1866M.

19 “(b) ELIGIBILITY CRITERIA.—In order to be eligible  
20 for an agreement under this section, an entity shall—

21 “(1) meet quality standards established by the  
22 Secretary;

23 “(2) implement an ongoing quality assurance  
24 program approved by the Secretary; and

25 “(3) meet such other requirements as the Sec-  
26 retary may establish.

1 “(c) PAYMENT.—

2 “(1) IN GENERAL.—The Secretary shall estab-  
3 lish criteria for identifying the health care items and  
4 services furnished by a center with an agreement  
5 under this section during an episode of care that are  
6 to be bundled together and for which payment shall  
7 be made on the basis of an all-inclusive rate.

8 “(2) PAYMENT LIMITATION.—

9 “(A) LIMITATION ON AGGREGATE PAY-  
10 MENTS TO ENTITIES.—The estimated amount  
11 of aggregate payments to all entities under this  
12 section for a year shall be less than the esti-  
13 mated amount of aggregate payments that the  
14 Secretary would otherwise have made for such  
15 year, adjusted for changes in the number of in-  
16 dividuals receiving services.

17 “(B) LIMITATION ON PAYMENTS TO PAR-  
18 TICULAR ENTITIES.—In no case shall the all-in-  
19 clusive rate paid to an entity for items and  
20 services furnished during an episode of care  
21 under this section exceed the estimated amount  
22 of the payments that the Secretary would other-  
23 wise have made for such items and services.

24 “(d) AGREEMENT PERIOD.—An agreement period  
25 shall be for up to three years (subject to renewal).

1       “(e) INCENTIVES FOR USE OF CENTERS.—Notwith-  
 2 standing any other provision of law, the Secretary may  
 3 permit entities under an agreement under this section to  
 4 furnish additional services or to waive part or all bene-  
 5 ficiary cost sharing (such as deductibles, copayments, and  
 6 coinsurance) with respect to any of the items or services  
 7 furnished under this section.

8       “(f) BENEFICIARY ELECTION.—Notwithstanding any  
 9 other provision of this title, an individual who voluntarily  
 10 elects to receive items and services under an arrangement  
 11 described in subsection (a)(1) with respect to an episode  
 12 of care shall not be entitled to payment under this title  
 13 for any such item or service furnished with respect to such  
 14 episode of care other than through such arrangement, sub-  
 15 ject to such exceptions as the Secretary may prescribe for  
 16 emergency medical services as described in section  
 17 1852(d)(3) and other cases of urgent need.”.

18 **SEC. 117. DEMONSTRATION OF BONUS PAYMENTS FOR**  
 19 **HEALTH CARE GROUPS.**

20       Title XVIII (42 U.S.C. 1395 et seq.), as previously  
 21 amended by this part, is further amended by adding after  
 22 section 1866F the following new section:

23 **“SEC. 1866G. DEMONSTRATION OF BONUS PAYMENTS FOR**  
 24 **HEALTH CARE GROUPS.**

25       “(a) DEMONSTRATION PROGRAM AUTHORIZED.—

1           “(1) IN GENERAL.—The Secretary shall con-  
2           duct demonstration projects to test and, if proven ef-  
3           fective, expand the use of incentives to health care  
4           groups participating in the program under this title  
5           that—

6                   “(A) encourage coordination of the care  
7                   furnished to individuals under the programs  
8                   under parts A and B by institutional and other  
9                   providers, practitioners, and suppliers of health  
10                  care items and services;

11                  “(B) encourage investment in administra-  
12                  tive structures and processes to ensure efficient  
13                  service delivery; and

14                  “(C) reward physicians for improving  
15                  health outcomes.

16           “(2) ADMINISTRATION BY CONTRACT.—Except  
17           as otherwise specifically provided, the Secretary may  
18           administer the program under this section in accord-  
19           ance with section 1866M.

20           “(3) DEFINITIONS.—For purposes of this sec-  
21           tion, terms have the following meanings:

22                   “(A) PHYSICIAN.—Except as the Secretary  
23                   may otherwise provide, the term ‘physician’  
24                   means any individual who furnishes services

1           which may be paid for as physicians' services  
2           under this title .

3           “(B) HEALTH CARE GROUP.—The term  
4           ‘health care group’ means a group of physicians  
5           (as defined in subparagraph (A)) organized at  
6           least in part for the purpose of providing physi-  
7           cians’ services under this title. As the Secretary  
8           finds appropriate, a health care group may in-  
9           clude a hospital and any other individual or en-  
10          tity furnishing items or services for which pay-  
11          ment may be made under this title that is affili-  
12          ated with the health care group under an ar-  
13          rangement structured so that such individual or  
14          entity participates in a demonstration under  
15          this section and will share in any bonus earned  
16          under subsection (d).

17          “(b) ELIGIBILITY CRITERIA.—

18                 “(1) IN GENERAL.—The Secretary is authorized  
19                 to establish criteria for health care groups eligible to  
20                 participate in a demonstration under this section, in-  
21                 cluding criteria relating to numbers of health care  
22                 professionals in, and of patients served by, the  
23                 group, scope of services provided, and quality of  
24                 care.

1           “(2) PAYMENT METHOD.—A health care group  
2 participating in the demonstration under this section  
3 shall agree with respect to services furnished to  
4 beneficiaries within the scope of the demonstration  
5 (as determined under subsection (c))—

6                   “(A) to be paid on a fee-for-service basis;  
7 and

8                   “(B) that payment with respect to all such  
9 services furnished by members of the health  
10 care group to such beneficiaries shall (where de-  
11 termined appropriate by the Secretary) be made  
12 to a single entity.

13           “(3) DATA REPORTING.—A health care group  
14 participating in a demonstration under this section  
15 shall report to the Secretary such data, at such  
16 times and in such format as the Secretary require,  
17 for purposes of monitoring and evaluation of the  
18 demonstration under this section.

19           “(c) PATIENTS WITHIN SCOPE OF DEMONSTRA-  
20 TION.—

21                   “(1) IN GENERAL.—The Secretary shall specify,  
22 in accordance with this subsection, the criteria for  
23 identifying those patients of a health care group who  
24 shall be considered within the scope of the dem-  
25 onstration under this section for purposes of applica-

1       tion of subsection (d) and for assessment of the ef-  
2       fectiveness of the group in achieving the objectives  
3       of this section.

4               “(2) OTHER CRITERIA.—The Secretary may es-  
5       tablish additional criteria for inclusion of bene-  
6       ficiaries within a demonstration under this section,  
7       which may include frequency of contact with physi-  
8       cians in the group or other factors or criteria that  
9       the Secretary finds to be appropriate.

10              “(3) NOTICE REQUIREMENTS.—In the case of  
11       each beneficiary determined to be within the scope  
12       of a demonstration under this section with respect to  
13       a specific health care group, the Secretary shall en-  
14       sure that such beneficiary is notified of the incen-  
15       tives, and of any waivers of coverage or payment  
16       rules, applicable to such group under such dem-  
17       onstration.

18              “(d) INCENTIVES.—

19               “(1) PERFORMANCE TARGET.—The Secretary  
20       shall establish for each health care group partici-  
21       pating in a demonstration under this section—

22                   “(A) a base expenditure amount, equal to  
23                   the average total payments under parts A, B,  
24                   and D for patients served by the health care

1 group on a fee-for-service basis in a base period  
2 determined by the Secretary; and

3 “(B) an annual per capita expenditure tar-  
4 get for patients determined to be within the  
5 scope of the demonstration, reflecting the base  
6 expenditure amount adjusted for risk and ex-  
7 pected growth rates.

8 “(2) INCENTIVE BONUS.—The Secretary shall  
9 pay to each participating health care group (subject  
10 to paragraph (4)) a bonus for each year under the  
11 demonstration equal to a portion of the Medicare  
12 savings realized for such year relative to the per-  
13 formance target.

14 “(3) ADDITIONAL BONUS FOR PROCESS AND  
15 OUTCOME IMPROVEMENTS.—At such time as the  
16 Secretary has established appropriate criteria based  
17 on evidence the Secretary determines to be suffi-  
18 cient, the Secretary shall also pay to a participating  
19 health care group (subject to paragraph (4)) an ad-  
20 ditional bonus for a year, equal to such portion as  
21 the Secretary may designate of the saving to the  
22 Medicare program resulting from process improve-  
23 ments made by and patient outcome improvements  
24 attributable to activities of the group.



1 “(2) section 1866B (disease management serv-  
2 ices);

3 “(3) section 1866C (competitive acquisition of  
4 items and services);

5 “(4) section 1866D (provider and physician col-  
6 laborations); and

7 “(5) section 1866E (preferred participants);

8 “(6) section 1866F (centers of excellence);

9 “(7) section 1866G (demonstration of bonus  
10 payments for health care groups).

11 “(b) PROVISIONS GENERALLY APPLICABLE TO DES-  
12 IGNATED PROGRAMS.—The following provisions apply to  
13 programs specified in subsection (a), except as otherwise  
14 specifically provided:

15 “(1) BENEFICIARY ELIGIBILITY.—Except as  
16 otherwise provided by the Secretary, an individual  
17 shall only be eligible to receive benefits under a pro-  
18 gram specified in subsection (a) if such individual—

19 “(A) is enrolled in under the program  
20 under part B;

21 “(B) is not enrolled in a Medicare+Choice  
22 plan under part C, an eligible organization  
23 under a contract under section 1876 (or a simi-  
24 lar organization operating under a demonstra-  
25 tion project authority), an organization with an

1 agreement under section 1833(a)(1)(A), or a  
2 PACE program under section 1894; and

3 “(C) in the case of the programs specified  
4 in paragraphs (1), (2), (4), (6), and (7) of sub-  
5 section (a), is entitled to benefits under part A.

6 “(2) SECRETARY’S DISCRETION AS TO SCOPE  
7 OF PROGRAM.—The Secretary may limit the imple-  
8 mentation of a program specified in subsection (a)  
9 to—

10 “(A) a geographic area (or areas) that the  
11 Secretary designates for purposes of the pro-  
12 gram, based upon such criteria as the Secretary  
13 finds appropriate;

14 “(B) a subgroup (or subgroups) of bene-  
15 ficiaries or individuals and entities furnishing  
16 items or services (otherwise eligible to partici-  
17 pate in the program), selected on the basis of  
18 the number of such participants that the Sec-  
19 retary finds consistent with the effective and ef-  
20 ficient implementation of the program;

21 “(C) an element (or elements) of the pro-  
22 gram that the Secretary determines to be suit-  
23 able for implementation; or

24 “(D) any combination of any of the limits  
25 described in subparagraphs (A) through (C).

1           “(3) VOLUNTARY RECEIPT OF ITEMS AND  
2 SERVICES.—Except as provided in the authority for  
3 the program specified in subsection (a)(3), items and  
4 services shall be furnished to an individual under the  
5 programs specified in subsection (a) only at the indi-  
6 vidual’s election.

7           “(4) AGREEMENTS.—The Secretary is author-  
8 ized to enter into agreements with individuals and  
9 entities to furnish health care items and services to  
10 beneficiaries under the programs specified in sub-  
11 section (a).

12           “(5) PROGRAM STANDARDS AND CRITERIA.—  
13 The Secretary shall establish performance standards  
14 for the programs specified in subsection (a) includ-  
15 ing, as applicable, standards for quality of health  
16 care items and services, cost-effectiveness, bene-  
17 ficiary satisfaction, and such other factors as the  
18 Secretary finds appropriate. The eligibility of indi-  
19 viduals or entities for the initial award, continuation,  
20 and renewal of agreements to provide health care  
21 items and services under the program shall be condi-  
22 tioned, at a minimum, on performance that meets or  
23 exceeds such standards.

24           “(6) ADMINISTRATIVE REVIEW OF ADVERSE  
25 DECISION.—

1           “(A) DECISIONS AFFECTING INDIVIDUALS  
2           AND ENTITIES FURNISHING SERVICES UNDER  
3           PROGRAMS.—An individual or entity furnishing  
4           services under a program specified in subsection  
5           (a) shall be entitled to a review by the program  
6           administrator (or, if the Secretary has not con-  
7           tracted with a program administrator, by the  
8           Secretary) of a decision not to enter into, or to  
9           terminate, or not to renew, an agreement with  
10          the individual or entity to provide health care  
11          items or services under such program.

12          “(B) DECISIONS AFFECTING BENE-  
13          FICIARIES UNDER CARE COORDINATION SERV-  
14          ICES OR DISEASE MANAGEMENT SERVICES PRO-  
15          GRAMS.—

16                 “(i) DETERMINATION OF INELIGI-  
17                 BILITY.—An individual shall be entitled to  
18                 a review by the program administrator (or,  
19                 if the Secretary has not contracted with a  
20                 program administrator, by the Secretary)  
21                 of a determination that the individual does  
22                 not meet the criteria for eligibility to par-  
23                 ticipate in a program specified in para-  
24                 graph (1) or (2) of subsection (a).

1                   “(ii) DENIAL OF PAYMENT FOR ITEMS  
2                   OR SERVICES.—A beneficiary shall be enti-  
3                   tled to a reconsideration or appeal of a de-  
4                   nial of payment under section 1866A(d)(2)  
5                   or 1866B(e)(2) in accordance with the pro-  
6                   visions of section 1852(g), as if such sec-  
7                   tion applied to this clause. In applying  
8                   such section 1852(g), any reference to a  
9                   Medicare+Choice organization is construed  
10                  to refer to the program administrator or, if  
11                  the Secretary has not contracted with a  
12                  program administrator, to the Secretary.

13                  “(7) SECRETARY’S REVIEW OF MARKETING MA-  
14                  TERIALS.—An agreement with an individual or enti-  
15                  ty furnishing services under a program specified in  
16                  subsection (a) shall require the individual or entity  
17                  to guarantee that it will not distribute materials  
18                  marketing items or services under such program  
19                  without the Secretary’s prior review and approval;

20                  “(8) PAYMENT IN FULL.—

21                  “(A) IN GENERAL.—Except as provided in  
22                  subparagraph (B), an individual or entity re-  
23                  ceiving payment from the Secretary under a  
24                  contract or agreement under a program speci-  
25                  fied in subsection (a) shall agree to accept such

1 payment as payment in full, and such payment  
2 shall be in lieu of any payments to which the  
3 individual or entity would otherwise be entitled  
4 under this title.

5 “(B) COLLECTION OF DEDUCTIBLES AND  
6 COINSURANCE.—Such individual or entity may  
7 collect any applicable deductible or coinsurance  
8 amount from a beneficiary.

9 “(c) CONTRACTS FOR PROGRAM ADMINISTRATION.—

10 “(1) IN GENERAL.—The Secretary may admin-  
11 ister a program specified in subsection (a) through  
12 a contract with a program administrator in accord-  
13 ance with the provisions of this subsection.

14 “(2) SCOPE OF PROGRAM ADMINISTRATOR CON-  
15 TRACTS.—A contract under this subsection may, at  
16 the Secretary’s discretion, relate to administration of  
17 any or all of the programs specified in subsection  
18 (a). The Secretary may enter into such contracts for  
19 a limited geographic area, or on a regional or na-  
20 tional basis.

21 “(3) ELIGIBLE CONTRACTORS.—The Secretary  
22 may contract for the administration of the program  
23 with—

24 “(A) an entity that, under a contract  
25 under section 1816 or 1842, determines the

1 amount of and makes payments for health care  
2 items and services furnished under this title; or

3 “(B) any other entity with substantial ex-  
4 perience in managing the type of program con-  
5 cerned.

6 “(4) CONTRACT AWARD, DURATION, AND RE-  
7 NEWAL.—

8 “(A) IN GENERAL.—A contract under this  
9 subsection shall be for an initial term of up to  
10 three years, renewable for additional terms of  
11 up to three years.

12 “(B) NONCOMPETITIVE AWARD AND RE-  
13 NEWAL FOR ENTITIES ADMINISTERING PART A  
14 OR PART B PAYMENTS.—The Secretary may  
15 enter or renew a contract under this subsection  
16 with an entity described in paragraph (3)(A)  
17 without regard to the requirements of section 5  
18 of title 41, United States Code.

19 “(5) APPLICABILITY OF FEDERAL ACQUISITION  
20 REGULATION.—The Federal Acquisition Regulation  
21 shall apply to program administration contracts  
22 under this subsection.

23 “(6) PERFORMANCE STANDARDS.—The Sec-  
24 retary shall establish performance standards for the  
25 program administrator including, as applicable,

1 standards for the quality and cost-effectiveness of  
2 the program administered, and such other factors as  
3 the Secretary finds appropriate. The eligibility of en-  
4 tities for the initial award, continuation, and renewal  
5 of program administration contracts shall be condi-  
6 tioned, at a minimum, on performance that meets or  
7 exceeds such standards.

8 “(7) FUNCTIONS OF PROGRAM ADMINIS-  
9 TRATOR.—A program administrator shall perform  
10 any or all of the following functions, as specified by  
11 the Secretary:

12 “(A) AGREEMENTS WITH INDIVIDUALS OR  
13 ENTITIES FURNISHING HEALTH CARE ITEMS  
14 AND SERVICES.—Determine the qualifications  
15 of individuals or entities seeking to enter or  
16 renew agreements to provide services under a  
17 program specified in subsection (a), and as ap-  
18 propriate enter or renew (or refuse to enter or  
19 renew) such agreements on behalf of the Sec-  
20 retary.

21 “(B) ESTABLISHMENT OF PAYMENT  
22 RATES.—Negotiate or otherwise establish, sub-  
23 ject to the Secretary’s approval, payment rates  
24 for covered health care items and services.

1           “(C) PAYMENT OF CLAIMS OR FEES.—Ad-  
2           minister payments for health care items or serv-  
3           ices furnished under any such program.

4           “(D) PAYMENT OF BONUSES.—Using such  
5           guidelines as the Secretary shall establish, and  
6           subject to the approval of the Secretary, make  
7           bonus payments as described in subsection  
8           (d)(2)(A)(ii) to individuals and entities fur-  
9           nishing items or services for which payment  
10          may be made under any such program.

11          “(E) LIST OF PROGRAM PARTICIPANTS.—  
12          Maintain and regularly update a list of individ-  
13          uals or entities with agreements to provide  
14          health care items and services under any such  
15          program, and ensure that such list, in electronic  
16          and hard copy formats, is readily available, as  
17          applicable, to—

18                 “(i) individuals residing in the service  
19                 area who are entitled to benefits under  
20                 part A or enrolled in the program under  
21                 part B;

22                 “(ii) the entities responsible under  
23                 sections 1816 and 1842 for administering  
24                 payments for health care items and serv-  
25                 ices furnished; and

1           “(iii) individuals and entities pro-  
2           viding health care items and services in the  
3           service area.

4           “(F) BENEFICIARY ENROLLMENT.—Deter-  
5           mine eligibility of individuals to enroll under a  
6           program specified in subsection (a) and provide  
7           enrollment-related services (but only if the Sec-  
8           retary finds that the program administrator has  
9           no conflict of interest caused by a financial re-  
10          lationship with any individual or entity fur-  
11          nishing items or services for which payment  
12          may be made under any such program, or any  
13          other conflict of interest with respect to such  
14          function).

15          “(G) OVERSIGHT.—Monitor the compli-  
16          ance of individuals and entities with agreements  
17          under any such program with the conditions of  
18          participation.

19          “(H) ADMINISTRATIVE REVIEW.—Conduct  
20          reviews of adverse determinations specified in  
21          subparagraph (A) and in subsection (b)(6).

22          “(I) REVIEW OF MARKETING MATE-  
23          RIALS.—Conduct a review of marketing mate-  
24          rials proposed by an individual or entity fur-  
25          nishing services under any such program.

1           “(J) ADDITIONAL FUNCTIONS.—Perform  
2           such other functions as the Secretary may  
3           specify.

4           “(8) LIMITATION OF LIABILITY.—The provi-  
5           sions of section 1157(b) shall apply with respect to  
6           activities of contractors and their officers, employ-  
7           ees, and agents under a contract under this sub-  
8           section.

9           “(9) INFORMATION SHARING.—Notwithstanding  
10          section 1106 and section 552a of title 5, United  
11          States Code, the Secretary is authorized to disclose  
12          to an entity with a program administration contract  
13          under this subsection such information (including  
14          medical information) on individuals receiving health  
15          care items and services under the program as the  
16          entity may require to carry out its responsibilities  
17          under the contract.

18          “(d) RULES APPLICABLE TO BOTH PROGRAM  
19          AGREEMENTS AND PROGRAM ADMINISTRATION CON-  
20          TRACTS.—

21                 “(1) RECORDS, REPORTS, AND AUDITS.—The  
22                 Secretary is authorized to require individuals and  
23                 entities with agreements to provide health care items  
24                 or services under programs specified under sub-  
25                 section (a), and entities with program administration

1 contracts under subsection (c), to maintain adequate  
2 records, to afford the Secretary access to such  
3 records (including for audit purposes), and to fur-  
4 nish such reports and other materials (including au-  
5 dited financial statements and performance data) as  
6 the Secretary may require for purposes of implemen-  
7 tation, oversight, and evaluation of such program  
8 and of individuals' and entities' effectiveness in per-  
9 formance of such agreements or contracts.

10 “(2) BONUSSES.—Notwithstanding any other  
11 provision of law, but subject to subparagraph  
12 (B)(ii), the Secretary may make bonus payments  
13 under a program specified in subsection (a) from the  
14 Health Insurance and Supplementary Medical Insur-  
15 ance Trust Funds in amounts that do not exceed  
16 50 percent of the savings to such Trust Funds at-  
17 tributable to such programs (or in the case of the  
18 program specified in subsection (a)(7), in amounts  
19 authorized under such program), in accordance with  
20 the following:

21 “(A) PAYMENTS TO PROGRAM ADMINIS-  
22 TRATORS.—The Secretary may make bonus  
23 payments under each program specified in sub-  
24 section (a) to program administrators.

1                   “(B) PAYMENTS TO INDIVIDUALS AND EN-  
2                   TITIES FURNISHING SERVICES.—

3                   “(i) IN GENERAL.—Subject to clause  
4                   (ii), the Secretary may make bonus pay-  
5                   ments to individuals or entities furnishing  
6                   items or services for which payment may  
7                   be made under the programs specified in  
8                   paragraphs (1), (2), (5), and (7) of sub-  
9                   section (a), or may authorize a program  
10                  administrator to make such bonus pay-  
11                  ments in accordance with such guidelines  
12                  as the Secretary shall establish and subject  
13                  to the Secretary’s approval.

14                  “(ii) LIMITATIONS.—The Secretary  
15                  may limit bonus payments under clause (i)  
16                  to particular service areas, types of individ-  
17                  uals or entities furnishing items or services  
18                  under a program, or kinds of items or  
19                  services, and may condition such payments  
20                  on the achievement of such standards re-  
21                  lated to efficiency, improvement in proc-  
22                  esses or outcomes of care, or such other  
23                  factors as the Secretary determines to be  
24                  appropriate.

25                  “(3) ANTIDISCRIMINATION LIMITATION.—

1           “(A) IN GENERAL.—The Secretary shall  
2           not enter into an agreement with an individual  
3           or entity to provide health care items or serv-  
4           ices under a program specified under subsection  
5           (a), or with an entity to administer such a pro-  
6           gram, unless such individual or entity guaran-  
7           tees that it will not deny, limit, or condition the  
8           coverage or provision of benefits under such  
9           program, for individuals eligible to be enrolled  
10          under such program, based on any health sta-  
11          tus-related factor described in section  
12          2702(a)(1) of the Public Health Service Act.

13           “(B) CONSTRUCTION.—Subparagraph (A)  
14          shall not be construed to prohibit such indi-  
15          vidual or entity from taking any action explic-  
16          itly authorized by the provisions of section  
17          1866A (care coordination services) or section  
18          1866B (disease management services).

19          “(e) LIMITATIONS ON JUDICIAL REVIEW.—The fol-  
20          lowing actions and determinations with respect to a pro-  
21          gram specified in subsection (a) shall not be subject to  
22          review by a judicial or administrative tribunal:

23                 “(1) limiting the implementation of a program  
24          under subsection (b)(2);

1           “(2) establishment of program participation  
2 standards under subsection (b)(5); or the denial or  
3 termination of, or refusal to renew, an agreement  
4 with an individual or entity to provide health care  
5 items and services under the program;

6           “(3) determination of a beneficiary’s eligibility  
7 under subsection (b)(6)(B);

8           “(4) establishment of program administration  
9 contract performance standards under subsection  
10 (c)(6); or the refusal to renew a program adminis-  
11 tration contract; or the noncompetitive award or re-  
12 newal of a program administration contract under  
13 subsection (c)(4)(B);

14           “(5) the establishment of payment rates,  
15 through negotiation or otherwise, under a program  
16 agreement or a program administration contract;

17           “(6) a determination with respect to a program  
18 (where specifically authorized by the program au-  
19 thority or by subsection (d)(2))—

20           “(A) as to whether cost savings have been  
21 achieved, and the amount of savings;

22           “(B) as to whether, to whom, and in what  
23 amounts bonuses will be paid; or

24           “(C) as to whether to reduce or eliminate  
25 beneficiary cost-sharing.

1       “(f) APPLICATION LIMITED TO PARTS A AND B.—  
2 None of the provisions of this section or of the programs  
3 specified in subsection (a) shall apply to the programs  
4 under parts C and D.”.

5       (b) EXCEPTION TO LIMITS ON PHYSICIAN REFER-  
6 RALS.—Section 1877(b) (42 U.S.C. 1395nn(b)) is  
7 amended—

8           (1) by redesignating paragraph (4) as para-  
9 graph (5); and

10          (2) by adding after paragraph (3) the following  
11 new paragraph:

12           “(4) PRIVATE SECTOR PURCHASING AND QUAL-  
13 ITY IMPROVEMENT TOOLS FOR ORIGINAL MEDI-  
14 CARE.—In the case of a designated health service, if  
15 the designated health service is—

16           “(A) included in the services under section  
17 1866A, 1866B, 1866D, or 1866F; and

18           “(B) is provided by an individual or entity  
19 meeting such criteria related to quality assur-  
20 ance, financial disclosure, and other factors as  
21 the Secretary may find appropriate.”.

1 **SEC. 119. REPORTS TO CONGRESS ON PRIVATE SECTOR**  
2 **PURCHASING AND QUALITY IMPROVEMENT**  
3 **PROGRAMS.**

4 Not later than two years after the date of enactment  
5 of the Medicare Modernization Act of 2000, and biennially  
6 thereafter for six years, the Secretary shall report to the  
7 Congress on the use of authorities enacted by sections 111  
8 through 117 of this Act. Each report shall address the  
9 impact of the use of those authorities on expenditures, ac-  
10 cess, and quality under the programs under title XVIII  
11 of the Social Security Act.

12 **SEC. 120. INCREASED FLEXIBILITY IN CONTRACTING FOR**  
13 **MEDICARE CLAIMS PROCESSING.**

14 (a) CARRIERS TO INCLUDE ENTITIES THAT ARE  
15 NOT INSURANCE COMPANIES.—

16 (1) The matter in section 1842(a) (42 U.S.C.  
17 1395u(a)) preceding paragraph (1) is amended by  
18 striking “with carriers” and inserting “with agencies  
19 and organizations (referred to as carriers)”.

20 (2) Section 1842(f) (42 U.S.C. 1395u(f)) is re-  
21 pealed.

22 (b) SECRETARIAL FLEXIBILITY IN CONTRACTING  
23 FOR AND IN ASSIGNING FISCAL INTERMEDIARY AND CAR-  
24 RIER FUNCTIONS.—

1           (1) Section 1816 (42 U.S.C. 1395h) is amended  
2           by striking everything after the heading but before  
3           subsection (b) and inserting the following:

4           “SEC. 1816. (a)(1) The Secretary may enter into con-  
5           tracts with agencies or organizations to perform any or  
6           all of the following functions, or parts of those functions  
7           (or, to the extent provided in a contract, to secure per-  
8           formance thereof by other organizations):

9           “(A) determine (subject to the provisions of sec-  
10          tion 1878 and to such review by the Secretary as  
11          may be provided for by the contracts) the amount of  
12          the payments required pursuant to this part to be  
13          made to providers of services,

14          “(B) make payments described in subparagraph  
15          (A),

16          “(C) provide consultative services to institutions  
17          or agencies to enable them to establish and maintain  
18          fiscal records necessary for purposes of this part and  
19          otherwise to qualify as providers of services,

20          “(D) serve as a center for, and communicate to  
21          individuals entitled to benefits under this part and  
22          to providers of services, any information or instruc-  
23          tions furnished to the agency or organization by the  
24          Secretary, and serve as a channel of communication

1 from individuals entitled to benefits under this part  
2 and from providers of services to the Secretary,

3 “(E) make such audits of the records of pro-  
4 viders of services as may be necessary to insure that  
5 proper payments are made under this part,

6 “(F) perform the functions described by sub-  
7 section (d), and

8 “(G) perform such other functions as are nec-  
9 essary to carry out the purposes of this part.

10 “(2) As used in this title and title XI, the term ‘fiscal  
11 intermediary’ means an agency or organization with a con-  
12 tract under this section.”.

13 (2) Subsections (d) and (e) of section 1816 (42  
14 U.S.C. 1395h) are amended to read as follows:

15 “(d) Each provider of services shall have a fiscal  
16 intermediary that—

17 “(1) acts as a single point of contact for the  
18 provider of services under this part,

19 “(2) makes its services sufficiently available to  
20 meet the needs of the provider of services, and

21 “(3) is responsible and accountable for arrang-  
22 ing the resolution of issues raised under this part by  
23 the provider of services.

1       “(e) The Secretary, in evaluating the performance of  
2 a fiscal intermediary, may solicit comments from providers  
3 of services.”.

4           (3)(A) Section 1816(b)(1)(A) (42 U.S.C.  
5 1395h(b)(1)(A)) is amended by striking “after ap-  
6 plying the standards, criteria, and procedures” and  
7 inserting “after evaluating the ability of the agency  
8 or organization to fulfill the contract performance  
9 requirements”.

10          (B) Section 1816(f)(1) (42 U.S.C. 1395h(f)(1))  
11 is amended to read as follows:

12       “(f)(1) The Secretary may consult with  
13 Medicare+Choice organizations under part C of this title,  
14 providers of services and other persons who furnish items  
15 or services for which payment may be made under this  
16 title, and organizations and agencies performing functions  
17 necessary to carry out the purposes of this part with re-  
18 spect to performance requirements for contracts under  
19 subsection (a).”.

20          (C) The second sentence of section  
21 1842(b)(2)(A) (42 U.S.C. 1395u(b)(2)(A)) is  
22 amended to read as follows: “The Secretary may  
23 consult with Medicare+Choice organizations under  
24 part C of this title, providers of services and other  
25 persons who furnish items or services for which pay-

1       ment may be made under this title, and organiza-  
2       tions and agencies performing functions necessary to  
3       carry out the purposes of this part with respect to  
4       performance requirements for contracts under sub-  
5       section (a).”.

6           (D) Section 1842(b)(2)(A) (42 U.S.C.  
7       1395u(b)(2)(A)) is amended by striking the third  
8       sentence.

9           (E) The matter in section 1842(b)(2)(B) (42  
10       U.S.C. 1395u(b)(2)(B)) preceding clause (i) is  
11       amended by striking “establish standards” and in-  
12       serting “develop contract performance require-  
13       ments”.

14          (F) Section 1842(b)(2)(D) (42 U.S.C.  
15       1395u(b)(2)(D)) is amended by striking “standards  
16       and criteria” each place it occurs and inserting  
17       “contract performance requirements”.

18          (4)(A) The matter in section 1816(b) (42  
19       U.S.C. 1395h(b)) preceding paragraph (1) is amend-  
20       ed by striking “an agreement” and inserting “a con-  
21       tract”.

22          (B) Paragraphs (1)(B) and (2)(A) of section  
23       1816(b) (42 U.S.C. 1395h(b)) are each amended by  
24       striking “agreement” and inserting “contract”.

1           (C) The first sentence of section 1816(c)(1) (42  
2 U.S.C. 1395h(c)(1)) is amended by striking “An  
3 agreement” and inserting “A contract”.

4           (D) The last sentence of section 1816(c)(1) (42  
5 U.S.C. 1395h(c)(1)) is amended by striking “an  
6 agreement” and inserting “a contract”.

7           (E) The matter in section 1816(c)(2)(A) (42  
8 U.S.C. 1395h(c)(2)(A)) preceding clause (i) is  
9 amended by striking “agreement” and inserting  
10 “contract”.

11           (F) Section 1816(c)(3)(A) (42 U.S.C.  
12 1395h(c)(3)(A)) is amended by striking “agree-  
13 ment” and inserting “contract”.

14           (G) Section 1816(h) (42 U.S.C. 1395h(h)) is  
15 amended—

16                 (i) by striking “An agreement” and insert-  
17                 ing “A contract”, and

18                 (ii) by striking “the agreement” each place  
19                 it occurs and inserting “the contract”.

20           (H) Section 1816(i)(1) (42 U.S.C. 1395h(i)(1))  
21 is amended by striking “an agreement” and insert-  
22           ing “a contract”.

23           (I) Section 1816(j) (42 U.S.C. 1395h(j)) is  
24 amended by striking “An agreement” and inserting  
25 “A contract”.

1           (J) Section 1816(k) (42 U.S.C. 1395h(k)) is  
2 amended by striking “An agreement” and inserting  
3 “A contract”.

4           (K) Section 1816(l) (42 U.S.C. 1395h(l)) is  
5 amended by striking “an agreement” and inserting  
6 “a contract”.

7           (L) The matter in section 1842(a) (42 U.S.C.  
8 1395u(a)) preceding paragraph (1) is amended by  
9 striking “agreements” and inserting “contracts”.

10           (M) Section 1842(h)(3)(A) (42 U.S.C.  
11 1395u(h)(3)(A)) is amended by striking “an agree-  
12 ment” and inserting “a contract”.

13           (5)(A) The matter in section 1816(c)(2)(A) (42  
14 U.S.C. 1395h(c)(2)(A)) preceding clause (i) is  
15 amended by inserting “that provides for making  
16 payments under this part” after “this section”.

17           (B) Section 1816(c)(3)(A) (42 U.S.C.  
18 1395h(c)(3)(A)) is amended by inserting “that pro-  
19 vides for making payments under this part” after  
20 “this section”.

21           (C) Section 1816(k) (42 U.S.C. 1395h(k)) is  
22 amended by inserting “(as appropriate)” after “sub-  
23 mit”.

24           (D) The matter in section 1842(a) (42 U.S.C.  
25 1395u(a)) preceding paragraph (1) is amended by

1 striking “some or all of the following functions” and  
2 inserting “any or all of the following functions, or  
3 parts of those functions”.

4 (E) The first sentence of section 1842(b)(2)(C)  
5 (42 U.S.C. 1395u(b)(2)(C)) is amended by inserting  
6 “(as appropriate)” after “carriers”.

7 (F) The matter preceding subparagraph (A) in  
8 the first sentence of section 1842(b)(3) (42 U.S.C.  
9 1395u(b)(3)) is amended by inserting “(as appro-  
10 priate)” after “contract”.

11 (G) The matter in section 1842(b)(7)(A) (42  
12 U.S.C. 1395u(b)(7)(A)) preceding clause (i) is  
13 amended by striking “the carrier” and inserting “a  
14 carrier”.

15 (H) The matter in section 1842(b)(11)(A) (42  
16 U.S.C. 1395u(b)(11)(A)) preceding clause (i) is  
17 amended by inserting “(as appropriate)” after “each  
18 carrier”.

19 (I) The first sentence of section 1842(h)(2) (42  
20 U.S.C. 1395u(h)(2)) is amended by inserting “(as  
21 appropriate)” after “shall”.

22 (J) Section 1842(h)(5)(A) (42 U.S.C.  
23 1395u(h)(5)(A)) is amended by inserting “(as ap-  
24 propriate)” after “carriers”.

1           (6)(A) Section 1816(e)(2)(C) (42 U.S.C.  
2           1395h(e)(2)(C)) is amended by striking “hospital,  
3           rural primary care hospital, skilled nursing facility,  
4           home health agency, hospice program, comprehen-  
5           sive outpatient rehabilitation facility, or rehabilita-  
6           tion agency” and inserting “provider of services”.

7           (B) The matter in section 1816(j) (42 U.S.C.  
8           1395h(j)) preceding paragraph (1) is amended by  
9           striking “for home health services, extended care  
10          services, or post-hospital extended care services”.

11          (7) Section 1842(a)(3) (42 U.S.C. 1395u(a)(3))  
12          is amended by inserting “(to and from individuals  
13          enrolled under this part and to and from physicians  
14          and other entities that furnish items and services)”  
15          after “communication”.

16          (8) The matter in section 1842(a) (42 U.S.C.  
17          1395u(a)) preceding paragraph (1), as amended by  
18          subsection (b)(4)(L), is amended by striking “car-  
19          riers with which contracts” and inserting “single  
20          contracts under section 1816 and this section to-  
21          gether, or separate contracts with eligible agencies  
22          and organizations with which contracts”.

23          (c) ELIMINATION OF SPECIAL PROVISIONS FOR TER-  
24          MINATIONS OF CONTRACTS.—

1           (1) The matter in section 1816(b) (42 U.S.C.  
2   1395h(b)) preceding paragraph (1) is amended by  
3   striking “or renew”.

4           (2) The last sentence of section 1816(c)(1) (42  
5   U.S.C. 1395h(c)(1)) is amended by striking “or re-  
6   newing”.

7           (3) Section 1816(g) (42 U.S.C. 1395h(g)) is re-  
8   pealed.

9           (4) The last sentence of section 1842(b)(2)(A)  
10   (42 U.S.C. 1395u(b)(2)(A)) is amended by striking  
11   “or renewing”.

12           (5) Section 1842(b) (42 U.S.C. 1395u(b)) is  
13   amended by striking paragraph (5).

14           (d) REPEAL OF FISCAL INTERMEDIARY REQUIRE-  
15   MENTS THAT ARE NOT COST-EFFECTIVE.—Section  
16   1816(f)(2) (42 U.S.C. 1395h(f)(2)) is amended to read  
17   as follows:

18           “(2) The contract performance requirements de-  
19   scribed in paragraph (1) shall include, with respect to  
20   claims for services furnished under this part by any pro-  
21   vider of services other than a hospital, whether such agen-  
22   cy or organization is able to process 75 percent of recon-  
23   siderations within 60 days and 90 percent of reconsider-  
24   ations within 90 days.”.

1 (e) REPEAL OF COST REIMBURSEMENT REQUIRE-  
2 MENTS.—

3 (1) The first sentence of section 1816(c)(1) (42  
4 U.S.C. 1395h(c)(1)) is amended—

5 (A) by striking the comma after “appro-  
6 priate” and inserting “and”, and

7 (B) by striking everything after “sub-  
8 section (a)” up to the period.

9 (2) Section 1816(c)(1) (42 U.S.C. 1395h(c)(1))  
10 is further amended by striking the second and third  
11 sentences.

12 (3) The first sentence of section 1842(c)(1) (42  
13 U.S.C. 1395h(c)(1)) is amended—

14 (A) by striking “shall provide” the first  
15 place it occurs and inserting “may provide”,  
16 and

17 (B) by striking everything after “this  
18 part” up to the period.

19 (4) Section 1842(c)(1) (42 U.S.C. 1395h(c)(1))  
20 is further amended by striking the remaining sen-  
21 tences.

22 (5) Section 2326(a) of the Deficit Reduction  
23 Act of 1984 (42 U.S.C. 1395h nt) is repealed.

1 (f) SECRETARIAL FLEXIBILITY WITH RESPECT TO  
2 RENEWING CONTRACTS AND TRANSFER OF FUNC-  
3 TIONS.—

4 (1) Section 1816(c) (42 U.S.C. 1395h(c)) is  
5 amended by adding at the end the following:

6 “(4)(A) Except as provided in laws with general  
7 applicability to Federal acquisition and procurement  
8 or in subparagraph (B), the Secretary shall use com-  
9 petitive procedures when entering into contracts  
10 under this section.

11 “(B)(i) The Secretary may renew a contract  
12 with a fiscal intermediary under this section from  
13 term to term without regard to section 5 of title 41,  
14 United States Code, or any other provision of law  
15 requiring competition, if the fiscal intermediary has  
16 met or exceeded the performance requirements es-  
17 tablished in the current contract.

18 “(ii) Functions may be transferred among fiscal  
19 intermediaries without regard to any provision of  
20 law requiring competition. However, the Secretary  
21 shall ensure that performance quality is considered  
22 in such transfers.”.

23 (2) Section 1842(b) (42 U.S.C. 1395u(b)) is  
24 amended by striking everything before paragraph (2)  
25 and inserting the following:

1           “(b)(1)(A) Except as provided in laws with general  
2 applicability to Federal acquisition and procurement or in  
3 subparagraph (B), the Secretary shall use competitive pro-  
4 cedures when entering into contracts under this section.

5           “(B)(i) The Secretary may renew a contract with a  
6 carrier under subsection (a) from term to term without  
7 regard to section 5 of title 41, United States Code, or any  
8 other provision of law requiring competition, if the carrier  
9 has met or exceeded the performance requirements estab-  
10 lished in the current contract.

11           “(ii) Functions may be transferred among carriers  
12 without regard to any provision of law requiring competi-  
13 tion. However, the Secretary shall ensure that perform-  
14 ance quality is considered in such transfers.”.

15           (g) WAIVER OF COMPETITIVE REQUIREMENTS FOR  
16 INITIAL CONTRACTS.—

17           (1) Contracts under section 1816(a) (42 U.S.C.  
18 1395h(a)) or 1842(a) (42 U.S.C. 1395u(a)) whose  
19 periods begin before or during the one year period  
20 that begins on the first day of the fourth calendar  
21 month that begins after the date of enactment of  
22 this section may be entered into without regard to  
23 any provision of law requiring competition.

24           (2) The amendments made by subsection (f)  
25 apply to contracts whose periods begin after the end

1 of the one year period specified in paragraph (1) of  
2 this subsection.

3 (h) EFFECTIVE DATES.—

4 (1) The amendments made by subsection (c)  
5 apply to contracts whose periods end at, or after, the  
6 end of the third calendar month that begins after  
7 the date of enactment of this section.

8 (2) The amendments made by subsections (a),  
9 (b), (d), and (e) apply to contracts whose periods  
10 begin after the third calendar month that begins  
11 after the date of enactment of this section.

12 **SEC. 121. SPECIAL PROVISIONS FOR FUNDING OF ACTIVI-**  
13 **TIES RELATED TO CERTAIN OVERPAYMENT**  
14 **RECOVERIES AND PROVIDER ENROLLMENT**  
15 **AND REVERIFICATION OF ELIGIBILITY.**

16 (a) FUNDING AVAILABLE UNDER THE MEDICARE IN-  
17 TEGRITY PROGRAM (MIP) APPROPRIATION FOR PRO-  
18 VIDER ENROLLMENT ACTIVITIES PERFORMED BY FISCAL  
19 INTERMEDIARIES AND CARRIERS.—Section 1817(k)(4)  
20 (42 U.S.C. 1395i(k)(4)) is amended—

21 (1) in subparagraph (A), by inserting “and the  
22 activities specified in subparagraph (C)” after “the  
23 Medicare Integrity Program under section 1893”;  
24 and

1           (2) by adding at the end the following new sub-  
2 paragraph:

3           “(C)(i) Of the amounts appropriated under  
4 subparagraph (A), the amounts specified in  
5 clause (iii) shall be available to the Secretary  
6 for payment of the costs of the activities de-  
7 scribed in clause (ii) which are performed by  
8 entities with contracts under section 1816 or  
9 1842.

10           “(ii) For purposes of clause (i), the activi-  
11 ties specified in this paragraph are—

12           “(I) determinations as to whether  
13 overpayments were made to an individual  
14 or entity furnishing items or services for  
15 which payment may be made under this  
16 title and recovery of any such overpay-  
17 ments; and

18           “(II) activities related to enrolling  
19 such individuals and entities under the  
20 program under this title, including estab-  
21 lishing billing privileges and records sys-  
22 tems, processing applications, background  
23 investigations, and related activities.

24           “(iii) For purposes of clause (i), the  
25 amount specified under this clause is the lesser

1 of the amounts necessary to perform the activi-  
2 ties described in clause (ii) or—

3 “(I) for fiscal year 2001,  
4 \$14,000,000; and

5 “(II) for fiscal years 2002 and 2003,  
6 the amount for the preceding year, in-  
7 creased by 30 percent of the difference be-  
8 tween the maximum amount specified in  
9 subparagraph (B) for such year and the  
10 maximum amount so specified for the pre-  
11 ceding year.

12 “(iv) Amounts available under this sub-  
13 paragraph for the activities described in clause  
14 (ii) shall be in addition to any amounts that  
15 may otherwise be available to carry out such ac-  
16 tivities.”.

17 (b) ADDITIONAL FUNCTIONS TO BE PERFORMED BY  
18 MIP CONTRACTORS.—

19 (1) REVERIFICATION OF ELIGIBILITY FUNC-  
20 TION.—Section 1893(b) (42 U.S.C. 1395ddd(b)) is  
21 amended by adding at the end the following new  
22 paragraph:

23 “(6) activities related to reverifying the eligi-  
24 bility of individuals and entities described in para-

1 graph (1) to participate under the program under  
2 this title, and related activities.

3 (2) PROVIDER ENROLLMENT AND OVERPAY-  
4 MENT RECOVERY FUNCTIONS ADDED AS MIP CON-  
5 TRACTOR FUNCTIONS AFTER PHASE-IN PERIOD.—

6 Section 1893(b) (42 U.S.C. 1395ddd(b)) is amended  
7 by adding at the end the following new paragraphs:

8 “(7) Activities related to enrolling individuals  
9 and entities described in paragraph (1) under the  
10 program under this title, including establishing bill-  
11 ing privileges and records systems, processing appli-  
12 cations, background investigations, and related ac-  
13 tivities.

14 “(8) Determinations with respect to overpay-  
15 ments made under this title that are discovered pur-  
16 suant to the performance of an activity described in  
17 paragraph (1) or (2), and recovery of any such over-  
18 payments.”.

19 (3) EFFECTIVE DATES.—The amendment made  
20 by paragraph (1) shall be effective on and after Oc-  
21 tober 1, 2000. The amendment made by paragraph  
22 (2) shall be effective on and after October 1, 2003.

1           **TITLE II—MODERNIZING**  
2           **MEDICARE BENEFITS**

3           **PART A—PRESCRIPTION DRUG BENEFIT**

4   **SEC. 201. PRESCRIPTION DRUG BENEFIT.**

5           (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et  
6 seq.) is amended—

7           (1) by redesignating section 1859 and part D  
8 as section 1858 and part F, respectively; and

9           (2) by adding after section 1858, as so redesign-  
10 nated, the following new part:

11           **“PART D—PRESCRIPTION DRUG BENEFIT FOR**  
12           **THE AGED AND DISABLED**

13           **“SEC. 1859. ESTABLISHMENT OF PRESCRIPTION DRUG BEN-**  
14           **EFIT PROGRAM FOR THE AGED AND DIS-**  
15           **ABLED.**

16           “There is hereby established a voluntary insurance  
17 program to provide prescription drug benefits in accord-  
18 ance with the provisions of this part for individuals who  
19 are aged or disabled or have end stage renal disease and  
20 who elect to enroll under such program, to be financed  
21 from premium payments by enrollees together with con-  
22 tributions from funds appropriated by the Federal Govern-  
23 ment.

1 **“SEC. 1859A. SCOPE OF BENEFITS.**

2 “(a) IN GENERAL.—The benefits provided to an indi-  
3 vidual enrolled in the insurance program under this part  
4 shall consist of—

5 “(1) payments made, in accordance with the  
6 provisions of this part, for covered prescription  
7 drugs (as specified in subsection (b)) dispensed by  
8 any pharmacy participating in the program under  
9 this part (and, in circumstances designated by the  
10 benefit manager, by a non-participating pharmacy),  
11 including any specifically named drug prescribed for  
12 the individual by a qualified health care professional  
13 regardless of whether the drug is included in a for-  
14 mulary established by the benefit manager if such  
15 drug is certified as medically necessary by such  
16 health care professional, up to the benefit limits  
17 specified in section 1859B; and

18 “(2) charging by participating pharmacies of—

19 “(A) the negotiated price for all covered  
20 prescription drugs, without regard to such ben-  
21 efit limit; and

22 “(B) the negotiated price (if any) estab-  
23 lished with respect to any drugs or classes of  
24 drugs described in subparagraphs (A) through  
25 (D) or (F) of section 1927(d)(2) that are avail-

1           able to individuals receiving benefits under this  
2           title.

3           “(b) COVERED PRESCRIPTION DRUGS.—

4           “(1) IN GENERAL.—Covered prescription drugs,  
5           for purposes of this part, include all prescription  
6           drugs (as defined in section 1859J(1)), including  
7           smoking cessation agents, except as otherwise pro-  
8           vided in this subsection.

9           “(2) EXCLUSIONS FROM COVERAGE.—Covered  
10          prescription drugs shall not include drugs or classes  
11          of drugs described in subparagraphs (A) through  
12          (D) and (F) through (H) of section 1927(d)(2) (ex-  
13          cept to the extent otherwise specifically provided by  
14          the Secretary with respect to a drug in any of such  
15          classes).

16          “(3) EXCLUSION OF PRESCRIPTION DRUGS TO  
17          THE EXTENT COVERED UNDER PART A OR B.—A  
18          drug prescribed for an individual that would other-  
19          wise be a covered prescription drug under this part  
20          shall not be so considered to the extent that pay-  
21          ment for such drug is available under part A or B  
22          (but shall be so considered to the extent that such  
23          payment is not available because benefits under part  
24          A or B have been exhausted).

1 **“SEC. 1859B. PAYMENT OF BENEFITS; BENEFIT LIMITS.**

2       “(a) PAYMENTS.—There shall be paid from the Pre-  
3 scription Drug Insurance Account within the Supple-  
4 mentary Medical Insurance Trust Fund (hereafter in this  
5 part referred to as the ‘Prescription Drug Insurance Ac-  
6 count’ or ‘the Insurance Account’), in the case of each in-  
7 dividual who is enrolled in the insurance program under  
8 this part and who purchases covered prescription drugs  
9 in a calendar year, an amount (not exceeding 50 percent  
10 of the applicable limit under subsection (b)) equal to 50  
11 percent of the negotiated price for each such covered pre-  
12 scription drug or such higher percentage as is proposed  
13 by a benefit manager pursuant to section 1859G(d)(8),  
14 if the Secretary finds that such percentage will not in-  
15 crease aggregate costs to the Insurance Account.

16       “(b) LIMIT.—

17               “(1) FOR 2003 THROUGH 2009.—For purposes  
18 of subsection (a), the limit under this subsection for  
19 2003 through 2009 is—

20                       “(A) \$2,000 for each of calendar years  
21 2003 and 2004;

22                       “(B) \$3,000 for each of calendar years  
23 2005 and 2006;

24                       “(C) \$4,000 for each of calendar years  
25 2007 and 2008; and

26                       “(D) \$5,000 for calendar year 2009.

1           “(2) FOR 2010 AND SUBSEQUENT YEARS.—For  
2 purposes of subsection (a), the limit under this sub-  
3 section for 2010 and each subsequent year is equal  
4 to the greater of the limit for the preceding year ad-  
5 justed by the percentage change in the consumer  
6 price index for all urban consumers (U.S. urban av-  
7 erage) for the 12-month period ending with June of  
8 the preceding year; or the limit for the preceding  
9 year.

10 **“SEC. 1859C. ELIGIBILITY AND ENROLLMENT.**

11           “(a) ELIGIBILITY.—Every individual who, in or after  
12 2003, is entitled to hospital insurance benefits under part  
13 A or enrolled in the medical insurance program under part  
14 B is eligible to enroll, in accordance with the provisions  
15 of this section, in the insurance program under this part,  
16 during an enrollment period prescribed in or under this  
17 section, in such manner and form as may be prescribed  
18 by regulations.

19           “(b) ENROLLMENT.—

20           “(1) IN GENERAL.—Each individual who satis-  
21 fies subsection (a) shall be enrolled (or eligible to en-  
22 roll) in the program under this part in accordance  
23 with the provisions of section 1837, as if that section  
24 applied to this part, except as otherwise explicitly  
25 provided in this part.

1           “(2) ENROLLMENT PERIOD.—Except as pro-  
2           vided in section 1859E or 1859H, or as otherwise  
3           explicitly provided, no individual shall be entitled to  
4           enroll in the program under this part at any time  
5           after the initial enrollment period.

6           “(3) SPECIAL ENROLLMENT PERIOD FOR  
7           2003.—

8           “(A) IN GENERAL.—An individual who  
9           first satisfies subsection (a) in 2003 may, at  
10          any time on or before December 31, 2003—

11           “(i) enroll in the program under this  
12          part; and

13           “(ii) enroll or re-enroll in such pro-  
14          gram after having previously declined or  
15          terminated enrollment in such program.

16          “(B) EFFECTIVE DATE OF COVERAGE.—

17          An individual who enrolls under the program  
18          under this part pursuant to subparagraph (A)  
19          shall be entitled to benefits under this part be-  
20          ginning on the first day of the month following  
21          the month in which such enrollment occurs.

22          “(e) PERIOD OF COVERAGE.—

23           “(1) IN GENERAL.—Except as otherwise pro-  
24          vided in this part, an individual’s coverage under the  
25          program under this part shall be effective for the pe-

1       riod provided in section 1838, as if that section ap-  
 2       plied to the program under this part.

3               “(2) PART D COVERAGE TERMINATED BY TER-  
 4       MINATION OF COVERAGE UNDER PARTS A AND B.—

5       In addition to the causes of termination specified in  
 6       section 1838, an individual’s coverage under this  
 7       part shall be terminated when the individual retains  
 8       coverage under neither the program under part A  
 9       nor the program under part B, effective on the effec-  
 10      tive date of termination of coverage under part A or  
 11      (if later) under part B.

12   **“SEC. 1859D. PREMIUMS.**

13               “(a) ANNUAL ESTABLISHMENT OF MONTHLY PRE-  
 14      MIUM RATES.—

15               “(1) IN GENERAL.—The Secretary shall, during  
 16      September of 2002 and of each succeeding year, de-  
 17      termine and promulgate a monthly premium rate for  
 18      the succeeding year in accordance with the provi-  
 19      sions of this subsection.

20               “(2) ACTUARIAL DETERMINATIONS.—

21               “(A) DETERMINATION OF ANNUAL BEN-  
 22      EFIT COSTS.—The Secretary shall estimate an-  
 23      nually for the succeeding year the amount equal  
 24      to the total of the benefits that will be payable  
 25      from the Insurance Account for prescription

1 drugs dispensed in such calendar year with re-  
2 spect to enrollees in the program under this  
3 part. In calculating such amount, the Secretary  
4 shall include an appropriate amount for a con-  
5 tingency margin.

6 “(B) DETERMINATION OF MONTHLY PRE-  
7 MIUM RATES.—

8 “(i) IN GENERAL.—The Secretary  
9 shall determine the monthly premium rate  
10 with respect to such enrollees for such suc-  
11 ceeding year, which shall be one-twelfth of  
12 the share specified in clause (ii) of the  
13 amount determined under subparagraph  
14 (A), divided by the total number of such  
15 enrollees, and rounded (if such rate is not  
16 a multiple of 10 cents) to the nearest mul-  
17 tiple of 10 cents.

18 “(ii) ENROLLEE AND EMPLOYER PER-  
19 CENTAGE SHARES.—The share specified in  
20 this clause, for purposes of clause (i), shall  
21 be—

22 “(I) one-half, in the case of pre-  
23 miums paid by an individual enrolled  
24 in the program under this part; and

1                   “(II) two-thirds, in the case of  
2                   premiums paid for such an individual  
3                   by a former employer (as defined in  
4                   section 1859H(f)(2)).

5                   “(3) PUBLICATION OF ASSUMPTIONS.—The  
6                   Secretary shall publish, together with the promulga-  
7                   tion of the monthly premium rates for the suc-  
8                   ceeding year, a statement setting forth the actuarial  
9                   assumptions and bases employed in arriving at the  
10                  amounts and rates determined under paragraphs (1)  
11                  and (2).

12                  “(b) PAYMENT OF PREMIUMS.—

13                   “(1) PAYMENTS BY DEDUCTION FROM SOCIAL  
14                   SECURITY, RAILROAD RETIREMENT BENEFITS, OR  
15                   BENEFITS ADMINISTERED BY OPM.—

16                   “(A) DEDUCTION FROM BENEFITS.—In  
17                   the case of an individual who is entitled to or  
18                   receiving benefits as described in subsection (a),  
19                   (b), or (d) of section 1840, premiums payable  
20                   under this part shall be collected by deduction  
21                   from such benefits at the same time and in the  
22                   same manner as premiums payable under part  
23                   B are collected pursuant to section 1840.

24                   “(B) TRANSFERS TO INSURANCE AC-  
25                   COUNT.—The Secretary of the Treasury shall,

1 from time to time, but not less often than quar-  
2 terly, transfer premiums collected pursuant to  
3 subparagraph (A) to the Insurance Account  
4 from the appropriate funds and accounts de-  
5 scribed in subsections (a)(2), (b)(2), and (d)(2)  
6 of section 1840, on the basis of the certifi-  
7 cations described in such subsections. The  
8 amounts of such transfers shall be appro-  
9 priately adjusted to the extent that prior trans-  
10 fers were too great or too small.

11 “(2) DIRECT PAYMENTS TO SECRETARY.—

12 “(A) ADDITIONAL PAYMENT BY EN-  
13 ROLLEE.—An individual to whom paragraph  
14 (1) applies (other than an individual receiving  
15 benefits as described in section 1840(d)) and  
16 who estimates that the amount that will be  
17 available for deduction under such paragraph  
18 for any premium payment period will be less  
19 than the amount of the monthly premiums for  
20 such period may (under regulations) pay to the  
21 Secretary the estimated balance, or such great-  
22 er portion of the monthly premium as the indi-  
23 vidual chooses.

24 “(B) PAYMENTS BY OTHER ENROLLEES.—

25 An individual enrolled in the insurance program

1 under this part with respect to whom none of  
2 the preceding provisions of this subsection ap-  
3 plies (or to whom section 1840(c) applies) shall  
4 pay premiums to the Secretary at such times  
5 and in such manner as the Secretary shall by  
6 regulations prescribe.

7 “(C) DEPOSIT OF PREMIUMS.—Amounts  
8 paid to the Secretary under this paragraph  
9 shall be deposited in the Treasury to the credit  
10 of the Prescription Drug Insurance Account in  
11 the Supplementary Medical Insurance Trust  
12 Fund.

13 “(d) CERTAIN LOW-INCOME INDIVIDUALS.—For  
14 rules concerning premiums for certain low-income individ-  
15 uals, see section 1859E.

16 **“SEC. 1859F. PRESCRIPTION DRUG INSURANCE ACCOUNT.**

17 “(a) IN GENERAL.—There is created within the Fed-  
18 eral Supplemental Medical Insurance Trust Fund estab-  
19 lished by section 1841 an account to be known as the ‘Pre-  
20 scription Drug Insurance Account’ (hereafter in this sec-  
21 tion referred to as the ‘Account’). The Account shall con-  
22 sist of such gifts and bequests as may be made as provided  
23 in section 201(i)(1), and such amounts as may be depos-  
24 ited in, or appropriated to, such fund as provided in this  
25 part. Funds provided under this part to the Account shall

1 be kept separate from all other funds within the Federal  
2 Supplemental Medical Insurance Trust Fund.

3 “(b) PAYMENTS FROM ACCOUNT.—The Managing  
4 Trustee shall pay from time to time from the Account such  
5 amounts as the Secretary of Health and Human Services  
6 certifies are necessary to make the payments provided for  
7 by this part, and the payments with respect to administra-  
8 tive expenses in accordance with section 201(g).

9 **“SEC. 1859G. ADMINISTRATION OF BENEFITS.**

10 “(a) IN GENERAL.—The Secretary shall provide for  
11 administration of the benefits under this part through a  
12 contract with a benefit manager designated in accordance  
13 with subsection (c), for enrolled individuals residing in  
14 each service area designated pursuant to subsection (b)  
15 (other than such individuals enrolled in a  
16 Medicare+Choice program under part C), in accordance  
17 with the provisions of this section.

18 “(b) DESIGNATION OF SERVICE AREAS.—

19 “(1) IN GENERAL.—The Secretary shall divide  
20 the total geographic area served by the programs  
21 under this title into at least fifteen service areas for  
22 purposes of administration of benefits under this  
23 part. Such division shall not be subject to adminis-  
24 trative or judicial review.

1           “(2) CONSIDERATIONS.—In determining or ad-  
2           justing the number and boundaries of service areas  
3           under this subsection, the Secretary shall seek to en-  
4           sure that—

5                   “(A) there is a reasonable expectation of a  
6                   meaningful level of competition among entities  
7                   eligible to contract to provide the benefit man-  
8                   agement services under this section for each  
9                   area; and

10                   “(B) the designation of areas is consistent  
11                   with the goal of securing contracts under this  
12                   section with respect to the maximum feasible  
13                   number of areas so designated.

14           “(c) DESIGNATION OF BENEFIT MANAGER.—

15                   “(1) AWARD AND DURATION OF CONTRACT.—  
16           The following shall apply to the award of a contract  
17           under this subsection with respect to a service area:

18                   “(A) COMPETITIVE AWARD.—Each con-  
19                   tract shall be awarded competitively in accord-  
20                   ance with section 5 of title 41, United States  
21                   Code, for a period (subject to subparagraph  
22                   (B)) of not less than three nor more than five  
23                   years.

24                   “(B) NONCOMPETITIVE EXTENSION.—The  
25           second and each succeeding contract for a serv-

1 ice area may be extended noncompetitively, at  
2 the discretion of the Secretary, for a total con-  
3 tract period not to exceed five years.

4 “(2) ELIGIBLE ENTITIES.—An entity eligi-  
5 ble for consideration as a benefit manager for  
6 a service area shall meet at least the following  
7 criteria:

8 “(A) TYPE.—The entity shall be any entity  
9 that the Secretary determines is capable of ad-  
10 ministering a prescription drug benefit pro-  
11 gram.

12 “(B) PERFORMANCE CAPABILITY.—The  
13 entity shall have sufficient expertise, personnel,  
14 and resources to perform effectively the benefit  
15 administration functions for such area.

16 “(C) INTEGRITY; FISCAL SOUNDNESS.—  
17 The entity and its officers, directors, agents,  
18 and managing employees shall have a satisfac-  
19 tory record of professional competence and pro-  
20 fessional and financial integrity, and the entity  
21 shall have financial resources the Secretary de-  
22 termines to be adequate to perform services  
23 under the contract without risk of insolvency.

1           “(3) PROPOSAL REQUIREMENTS.—An entity’s  
2 proposal for award or renewal of a contract under  
3 this section shall—

4           “(A) include a cost proposal setting forth  
5 the entity’s proposed charges for administration  
6 of the prescription drug benefit;

7           “(B) include a proposal for the prices of  
8 drugs and annual increases in such prices, in-  
9 cluding differentials between formulary and  
10 non-formulary prices, if applicable (and at the  
11 entity’s election, include a proposal described in  
12 subsection (d)(8));

13           “(C) specify details of proposed cost and  
14 utilization management, error reduction, and  
15 quality assurance measures;

16           “(D) be accompanied by such information  
17 as the Secretary may require on the entity’s  
18 past performance;

19           “(E) disclose ownership and shared finan-  
20 cial interests with other entities involved in the  
21 delivery of the benefit as proposed;

22           “(F) include a proposal for working with  
23 the Secretary to deter medical errors related to  
24 prescription drugs; and

1           “(G) include such other material and infor-  
2           mation as the Secretary may require.

3           “(4) CRITERIA FOR COMPETITIVE SELEC-  
4           TION.—In awarding a contract competitively, the  
5           Secretary shall consider the comparative merits of  
6           each of the applications by eligible entities, as deter-  
7           mined on the basis of the entities’ past performance  
8           and other relevant factors, with respect to the fol-  
9           lowing:

10           “(A) the estimated total cost of the con-  
11           tract, taking into consideration the entity’s pro-  
12           posed fees and price and cost estimates, as eval-  
13           uated and adjusted by the Secretary in accord-  
14           ance with the provisions of the Federal Acquisi-  
15           tion Regulation concerning contracting by nego-  
16           tiation;

17           “(B) prior experience in administering a  
18           prescription drug benefit program;

19           “(C) effectiveness in containing costs  
20           through pricing incentives and utilization man-  
21           agement;

22           “(D) the quality and efficiency of benefit  
23           management services with respect to such mat-  
24           ters as claims processing and benefits coordina-  
25           tion; record-keeping and reporting; and drug

1 utilization review, patient information, and  
2 other activities supporting quality of care; and

3 “(E) such other factors as the Secretary  
4 deems necessary to evaluate the merits of each  
5 application.

6 “(5) EXCEPTIONS TO CONFLICT OF INTEREST  
7 RULES.—In awarding contracts under this sub-  
8 section, the Secretary may waive conflict of interest  
9 rules generally applicable to Federal acquisitions  
10 (subject to such safeguards as the Secretary may  
11 find necessary to impose) in circumstances where the  
12 Secretary finds that such waiver—

13 “(A) is not inconsistent with the purposes  
14 of the programs under this title and the best in-  
15 terests of enrolled individuals; and

16 “(B) will permit a sufficient level of com-  
17 petition for such contracts, promote efficiency  
18 of benefits administration, or otherwise serve  
19 the objectives of the program under this part.

20 “(6) MAXIMIZING COMPETITION.—In awarding  
21 contracts under this section, the Secretary shall give  
22 consideration to the need to maintain sufficient  
23 numbers of entities eligible and willing to administer  
24 benefits under this part to ensure vigorous competi-  
25 tion for such contracts.

1       “(d) FUNCTIONS OF BENEFIT MANAGER.—The ben-  
2       efit manager for a service area shall (or in the case of  
3       the function described in paragraph (8), may) perform  
4       some or all of the following functions, as specified by the  
5       Secretary:

6               “(1) PARTICIPATION AGREEMENTS, PRICES,  
7       AND FEES.—

8               “(A) SCHEDULE OF COVERED DRUG  
9       PRICES.—Establish, through negotiations with  
10       drug manufacturers and wholesalers and phar-  
11       macies, a schedule of prices for covered pre-  
12       scription drugs. Such negotiated prices shall not  
13       be subject to administrative or judicial review.

14              “(B) AGREEMENTS WITH PHARMACIES.—  
15       Enter into participation agreements under sub-  
16       section (e) with qualifying pharmacies, on terms  
17       that—

18              “(i) secure the participation of suffi-  
19       cient numbers of pharmacies to ensure  
20       convenient access (including adequate  
21       emergency access); and

22              “(ii) permit the participation of any  
23       pharmacy in the service area that meets  
24       the participation requirements described in  
25       subsection (e).

1           “(C) LISTS OF PRICES AND PARTICIPATING  
2 PHARMACIES.—Ensure that the negotiated  
3 prices established under subparagraph (A) and  
4 the list of pharmacies with agreements under  
5 subsection (e) are regularly updated and readily  
6 available in the service area to health care pro-  
7 fessionals authorized to prescribe drugs, partici-  
8 pating pharmacies, and enrolled individuals.

9           “(2) TRACKING OF COVERED ENROLLED INDI-  
10 VIDUALS.—Maintain accurate, updated records of all  
11 enrolled individuals residing in the service area  
12 (other than individuals enrolled in a plan under part  
13 C).

14           “(3) PAYMENT AND COORDINATION OF BENE-  
15 FITS.—

16           “(A) IN GENERAL.—Administer claims for  
17 payment of benefits under this part; determine  
18 amounts of benefit payments to be made; and  
19 receive, disburse, and account for funds used in  
20 making such payments, including through the  
21 activities specified in the provisions of this  
22 paragraph.

23           “(B) COORDINATION AND PAYMENT OF  
24 BENEFITS.—Coordinate with the Secretary,  
25 other benefit managers, pharmacies and other

1 relevant entities as necessary to ensure appro-  
2 priate coordination of benefits with respect to  
3 enrolled individuals, including coordination of  
4 access to and payment for covered prescription  
5 drugs according to an individual's in-service  
6 area plan provisions, when such individual is  
7 traveling outside the home service area, and  
8 under such other circumstances as the Sec-  
9 retary may specify.

10 “(C) EXPLANATION OF BENEFITS.—Fur-  
11 nish to enrolled individuals an explanation of  
12 benefits in accordance with section 1806(a),  
13 and a notice of the balance of benefits remain-  
14 ing for the current year, whenever prescription  
15 drug benefits are provided under this part (ex-  
16 cept that such notice need not be provided more  
17 often than monthly).

18 “(4) COST AND UTILIZATION MANAGEMENT;  
19 QUALITY ASSURANCE.—Have in place effective cost  
20 and utilization management, quality assurance meas-  
21 ures, and systems to reduce medical errors, includ-  
22 ing at least the following, together with such addi-  
23 tional measures as the Secretary may specify:

24 “(A) DRUG UTILIZATION REVIEW.—A drug  
25 utilization review program conforming to the

1 standards provided in section 1927(g)(2) (with  
2 such modifications as the Secretary finds ap-  
3 propriate for operation of such program by an  
4 entity other than a State).

5 “(B) FRAUD AND ABUSE CONTROL.—Ac-  
6 tivities to control fraud, abuse, and waste.

7 “(5) EDUCATION AND INFORMATION ACTIVI-  
8 TIES.—Have in place mechanisms for disseminating  
9 educational and informational materials to enrolled  
10 individuals and health care providers designed to en-  
11 courage effective and cost-effective use of prescrip-  
12 tion drug benefits and to ensure that enrolled indi-  
13 viduals understand their rights and obligations  
14 under the program.

15 “(6) BENEFICIARY PROTECTIONS.—

16 “(A) CONFIDENTIALITY OF HEALTH IN-  
17 FORMATION.—Have in effect systems to safe-  
18 guard the confidentiality of health care infor-  
19 mation on enrolled individuals, which comply  
20 with section 1106 and with section 552a of title  
21 5, United States Code, and meet such addi-  
22 tional standards as the Secretary may pre-  
23 scribe.

24 “(B) GRIEVANCE AND APPEAL PROCE-  
25 DURES.—Have in place such procedures as the

1 Secretary may specify for hearing and resolving  
2 grievances and appeals brought by enrolled in-  
3 dividuals against the benefit manager or a  
4 pharmacy concerning benefits under this part,  
5 which shall, to the extent the Secretary finds  
6 necessary and appropriate, include procedures  
7 equivalent to those specified in subsections (f)  
8 and (g) of section 1852.

9 “(7) RECORDS, REPORTS, AND AUDITS OF BEN-  
10 EFIT MANAGERS.—

11 “(A) RECORDS AND AUDITS.—Maintain  
12 adequate records, and afford the Secretary ac-  
13 cess to such records (including for audit pur-  
14 poses).

15 “(B) REPORTS.—Make such reports and  
16 submissions of financial and utilization data as  
17 the Secretary may require taking into account  
18 standard commercial practices.

19 “(8) PROPOSAL FOR ALTERNATIVE COINSUR-  
20 ANCE AMOUNT.—At the benefit manager’s election,  
21 provide a proposal for increased Government cost  
22 sharing for generic prescription drugs, prescription  
23 drugs on the benefit manager’s formulary, or pre-  
24 scription drugs obtained through mail order phar-  
25 macies, which includes evidence that such increased

1 cost sharing would not result in an increase in ag-  
2 gregate costs to the Account including an analysis of  
3 differences in projected drug utilization patterns by  
4 beneficiaries whose cost sharing would be reduced  
5 under the proposal and those making the cost-shar-  
6 ing payments that would otherwise apply.

7 “(9) OTHER REQUIREMENTS.—Meet such other  
8 requirements as the Secretary may specify.

9 “(e) PHARMACY PARTICIPATION AGREEMENTS.—

10 “(1) IN GENERAL.—A pharmacy that meets the  
11 requirements of this subsection shall be eligible to  
12 enter an agreement with a benefit manager to fur-  
13 nish covered prescription drugs to enrolled individ-  
14 uals residing in the service area.

15 “(2) TERMS OF AGREEMENT.—An agreement  
16 under this subsection shall include the following  
17 terms and requirements:

18 “(A) LICENSING.—The pharmacy shall  
19 meet (and throughout the contract period will  
20 continue to meet) all applicable State and local  
21 licensing requirements.

22 “(B) ACCESS AND QUALITY STANDARDS.—  
23 The pharmacy shall comply with such standards  
24 as the Secretary and the benefit manager shall  
25 establish concerning the quality of, and enrolled

1 individuals' access to, pharmacy services under  
2 this part.

3 “(C) ADHERENCE TO ESTABLISHED  
4 PRICES.—The total charge for each drug dis-  
5 pensed to an enrolled individual, without regard  
6 to whether such individual is financially respon-  
7 sible for any or all of such charge, shall not ex-  
8 ceed the negotiated price for the drug, as estab-  
9 lished under subsection (d)(1)(A) with respect  
10 to the service area in which the enrolled indi-  
11 vidual resides.

12 “(D) MANAGEMENT SYSTEMS AND PROCE-  
13 DURES.—The pharmacy shall—

14 “(i) have in effect management sys-  
15 tems (including electronic systems) and  
16 procedures for carrying out functions  
17 under the agreement; and

18 “(ii) maintain adequate records, af-  
19 ford the benefit manager access to such  
20 records for audit purposes, and make such  
21 reports as the benefit manager may require  
22 to meet its responsibilities under this sec-  
23 tion.

24 “(E) COST AND UTILIZATION MANAGE-  
25 MENT; QUALITY ASSURANCE.—The pharmacy

1 shall implement effective measures for quality  
2 assurance, cost management, and reduction of  
3 medical errors with respect to drugs dispensed  
4 under the agreement, including maintenance of  
5 utilization records and participation in the drug  
6 utilization review program described in sub-  
7 section (d)(4)(A).

8 “(F) CONFIDENTIALITY PROTECTIONS.—  
9 The pharmacy shall have in effect systems to  
10 ensure compliance with the confidentiality  
11 standards applicable under subsection  
12 (d)(6)(A).

13 “(G) OTHER REQUIREMENTS.—The phar-  
14 macy shall meet such other requirements as the  
15 Secretary may impose.

16 (f) LIMITATION OF LIABILITY.—The provisions of  
17 section 1157(b) shall apply with respect to activities of  
18 benefit managers and their officers, employees, and agents  
19 under a contract under this section.

20 (g) INCENTIVES FOR COST AND UTILIZATION MAN-  
21 AGEMENT AND QUALITY IMPROVEMENT.—The Secretary  
22 is authorized to include in a contract awarded under sub-  
23 section (c)(4) such incentives for cost and utilization man-  
24 agement and quality improvement as the Secretary may  
25 deem appropriate, including—

1           “(1) bonus and penalty incentives to encourage  
2       administrative efficiency;

3           “(2) incentives under which benefit managers  
4       share in any benefit savings achieved;

5           “(3) risk sharing arrangements related to ben-  
6       efit payments; and

7           “(4) any other incentive that the Secretary  
8       deems appropriate and likely to be effective in man-  
9       aging costs or utilization.

10       “(h) FLEXIBILITY IN ASSIGNING WORKLOAD AMONG  
11   BENEFIT MANAGERS.—During the period after the Sec-  
12   retary has given notice of intent to terminate a contract  
13   under subsection (c)(4), the Secretary may transfer re-  
14   sponsibilities of the benefit manager under such contract  
15   to another benefit manager.

16       “(i) NONINTERFERENCE.—Nothing in this section or  
17   in this part shall be construed as authorizing the Secretary  
18   to authorize a particular formulary or to institute a price  
19   structure for benefits, or to otherwise interfere with the  
20   competitive nature of providing a prescription drug benefit  
21   through benefit managers.

1 **“SEC. 1859H. EMPLOYER INCENTIVE PROGRAM FOR EM-**  
2 **PLOYMENT-BASED RETIREE DRUG COV-**  
3 **ERAGE.**

4 “(a) PROGRAM AUTHORITY.—The Secretary is au-  
5 thorized to develop and implement a program under this  
6 section called the Employer Incentive Program that en-  
7 courages employers and other sponsors of employment-  
8 based health care coverage to provide adequate prescrip-  
9 tion drug benefits to retired individuals by subsidizing, in  
10 part, the sponsor’s cost of providing coverage under quali-  
11 fying plans.

12 “(b) SPONSOR REQUIREMENTS.—In order to be eligi-  
13 ble to receive an incentive payment under this section with  
14 respect to coverage of an individual under a qualified re-  
15 tiree prescription drug plan (as defined in subsection  
16 (f)(3)), a sponsor shall meet the following requirements:

17 “(1) ASSURANCES.—The sponsor shall—

18 “(A) annually attest, and provide such as-  
19 surances as the Secretary may require, that the  
20 coverage offered by the sponsor is a qualified  
21 retiree prescription drug plan, and will remain  
22 such a plan for the duration of the sponsor’s  
23 participation in the program under this section;  
24 and

25 “(B) guarantee that it will give notice to  
26 the Secretary and covered retirees—

1                   “(i) at least 120 days before termi-  
2                   nating its plan, and

3                   “(ii) immediately upon determining  
4                   that the actuarial value of the prescription  
5                   drug benefit under the plan falls below the  
6                   actuarial value of the insurance benefit  
7                   under this part.

8                   “(2) BENEFICIARY INFORMATION.—The spon-  
9                   sor shall report to the Secretary, for each calendar  
10                  quarter for which it seeks an incentive payment  
11                  under this section the names and social security  
12                  numbers of all retirees (and their spouses and de-  
13                  pendents) covered under such plan during such  
14                  quarter and the dates (if less than the full quarter)  
15                  during which each such individual was covered.

16                  “(3) AUDITS.—The sponsor and the employ-  
17                  ment-based retiree health coverage plan seeking in-  
18                  centive payments under this section shall agree to  
19                  maintain, and to afford the Secretary access to, such  
20                  records as the Secretary may require for purposes of  
21                  audits and other oversight activities necessary to en-  
22                  sure the adequacy of prescription drug coverage, the  
23                  accuracy of incentive payments made, and such  
24                  other matters as may be appropriate.

1           “(4) OTHER REQUIREMENTS.—The sponsor  
2 shall provide such other information, and comply  
3 with such other requirements, as the Secretary may  
4 find necessary to administer the program under this  
5 section.

6           “(c) INCENTIVE PAYMENT.—

7           “(1) IN GENERAL.—A sponsor that meets the  
8 requirements of subsection (b) with respect to a  
9 quarter in a calendar year shall be entitled to have  
10 payment made on a quarterly basis (to the sponsor  
11 or, at the sponsor’s direction, to the appropriate em-  
12 ployment-based health plan) of an incentive pay-  
13 ment, in the amount determined as described in  
14 paragraph (2), for each retired individual (or  
15 spouse) who—

16                   “(A) was covered under the sponsor’s  
17 qualified retiree prescription drug plan during  
18 such quarter; and

19                   “(B) was eligible for but was not enrolled  
20 in the insurance program under this part.

21           “(2) AMOUNT OF INCENTIVE.—The payment  
22 under this section with respect to each individual de-  
23 scribed in paragraph (1) for a month shall be equal  
24 to two-thirds of the monthly premium amount pay-

1       able by an enrolled individual, as set for the cal-  
2       endar year pursuant to section 1859D(a)(2).

3           “(3) PAYMENT DATE.—The incentive under  
4       this section with respect to a calendar quarter shall  
5       be payable as of the end of the next succeeding cal-  
6       endar quarter.

7           “(d) CIVIL MONEY PENALTIES.—A sponsor, health  
8       plan, or other entity that the Secretary determines has,  
9       directly or through its agent, provided information in con-  
10      nection with a request for an incentive payment under this  
11      section that the entity knew or should have known to be  
12      false shall be subject to a civil monetary penalty in an  
13      amount up to three times the total incentive amounts  
14      under subsection (c) that were paid (or would have been  
15      payable) on the basis of such information.

16          “(e) PART D ENROLLMENT FOR CERTAIN INDIVID-  
17      UALS COVERED BY EMPLOYMENT-BASED RETIREE  
18      HEALTH COVERAGE PLANS.—

19           “(1) ELIGIBLE INDIVIDUALS.—An individual  
20      shall be given the opportunity to enroll in the pro-  
21      gram under this part during the period specified in  
22      paragraph (2) if—

23           “(A) the individual declined enrollment in  
24      the program under this part at the time the in-  
25      dividual first satisfied section 1859C(a);

1           “(B) at that time, the individual was cov-  
2           ered under a qualified retiree prescription drug  
3           plan for which an incentive payment was paid  
4           under this section; and

5           “(C)(i) the sponsor subsequently ceased to  
6           offer such plan; or

7           “(ii) the value of prescription drug cov-  
8           erage under such plan became less than the  
9           value of the coverage under the program under  
10          this part.

11          “(2) SPECIAL ENROLLMENT PERIOD.—An indi-  
12          vidual described in paragraph (1) shall be eligible to  
13          enroll in the program under this part during the six-  
14          month period beginning on the first day of the  
15          month in which—

16                 “(A) the individual receives a notice that  
17                 coverage under such plan has terminated (in  
18                 the circumstance described in paragraph  
19                 (1)(C)(i)) or notice that a claim has been de-  
20                 nied because of such a termination; or

21                 “(B) the individual received notice of the  
22                 change in benefits (in the circumstance de-  
23                 scribed in subparagraph (1)(C)(ii)).

24          “(f) DEFINITIONS.—As used in this section, terms  
25          have the following meanings:

1           “(1) EMPLOYMENT-BASED RETIREE HEALTH  
2           COVERAGE.—The term ‘employment-based retiree  
3           health coverage’ means health insurance or other  
4           coverage of health care costs for retired individuals  
5           (or for such individuals and their spouses and de-  
6           pendents) based on their status as former employees  
7           or labor union members.

8           “(2) EMPLOYER.—The term ‘employer’ has the  
9           meaning given such term by section 3(5) of the Em-  
10          ployee Retirement Income Security Act of 1974 (ex-  
11          cept that such term shall include only employers of  
12          two or more employees).

13          “(3) QUALIFIED RETIREE PRESCRIPTION DRUG  
14          PLAN.—The term ‘qualified retiree prescription drug  
15          plan’ means health insurance coverage included in  
16          employment-based retiree health coverage that—

17                 “(A) provides coverage of the cost of pre-  
18                 scription drugs whose actuarial value (as de-  
19                 fined by the Secretary) to each retired bene-  
20                 ficiary equals or exceeds the actuarial value of  
21                 the benefits provided to an individual enrolled  
22                 in the program under this part; and

23                 “(B) does not deny, limit, or condition the  
24                 coverage or provision of prescription drug bene-  
25                 fits for retired individuals based on age or any

1 health status-related factor described in section  
2 2702(a)(1) of the Public Health Service Act.

3 “(4) SPONSOR.—The term ‘sponsor’ means  
4 plan sponsor as defined in section 3(16) of the Em-  
5 ployer Retirement Income Security Act of 1974.

6 (g) APPROPRIATIONS TO COVER INCENTIVES FOR  
7 EMPLOYMENT-BASED RETIREE DRUG COVERAGE.—  
8 There are authorized to be appropriated from time to  
9 time, out of any moneys in the Treasury not otherwise  
10 appropriated such sums as may be necessary for payment  
11 of incentive payments under subsection (c).

12 **“SEC. 1859I. APPROPRIATIONS TO COVER GOVERNMENT**  
13 **CONTRIBUTIONS.**

14 “There are authorized to be appropriated from time  
15 to time, out of any moneys in the Treasury not otherwise  
16 appropriated, to the Prescription Drug Insurance Ac-  
17 count, a Government contribution equal to—

18 “(1) the aggregate premiums payable for a  
19 month pursuant to section 1859D(a)(2) by individ-  
20 uals enrolled in the program under this part, plus

21 “(2) one-half the aggregate premiums payable  
22 for a month pursuant to such section for such indi-  
23 viduals by former employers.

1 **“SEC. 1859J. DEFINITION.**

2 “As used in this part, the term ‘prescription drug’  
3 means—

4 “(1) a drug that may be dispensed only upon  
5 a prescription, and that is described in subpara-  
6 graph (A)(i), (A)(ii), or (B) of section 1927(k)(2);  
7 and

8 “(2) insulin certified under section 506 of the  
9 Federal Food, Drug, and Cosmetic Act, and needles,  
10 syringes, and disposable pumps for the administra-  
11 tion of such insulin.”.

12 (b) **STUDY OF ANNUAL OPEN ENROLLMENT.**—Dur-  
13 ing 2003 and 2004, the Secretary shall study the feasi-  
14 bility and advisability of establishing an annual open en-  
15 rollment period for the program under part D (as added  
16 by subsection (a)). Such study shall reflect data reported  
17 by benefit managers administering benefits under such  
18 part and shall include:

19 (1) a review of the costs, effectiveness, and ad-  
20 ministrative feasibility of an annual open enrollment  
21 period for beneficiaries who previously declined en-  
22 rollment or who previously disenrolled and desire to  
23 re-enroll;

24 (2) an evaluation of a premium penalty for late  
25 enrollment based on actuarially determined costs to  
26 the program of late enrollment; and

1           (3) a projection of the costs to the program  
2           under such part through 2010 of an annual open en-  
3           rollment period.

4           The Secretary shall prepare a report setting forth the out-  
5           come of the study, and may include in the report a rec-  
6           ommendation as to whether an annual open enrollment pe-  
7           riod should be implemented under such part.

8           (c) CONFORMING AMENDMENTS.—

9           (1) AMENDMENTS TO FEDERAL SUPPLE-  
10          MENTARY HEALTH INSURANCE TRUST FUND.—Sec-  
11          tion 1841 (42 U.S.C. 1395t) is amended—

12           (A) in the last sentence of subsection (a)—

13                   (i) by striking “and such amounts”  
14                   and replacing it with “such amounts”; and

15                   (ii) by adding the following before the  
16                   period: “and such amounts as may be de-  
17                   posited in, or appropriated to, the Pre-  
18                   scription Drug Insurance Account estab-  
19                   lished by section 1859F”;

20           (B) in subsection (g), by inserting after  
21           “by this part,” the following: “the payments  
22           provided for under part D (in which case the  
23           payments shall come from the Prescription  
24           Drug Insurance Account in the Supplementary  
25           Medical Insurance Trust Fund),”;

1 (C) in subsection (h), by adding at the end  
 2 of the first sentence: “and section 1859D(b)(4)  
 3 (in which case the payments shall come from  
 4 the Prescription Drug Insurance Account in the  
 5 Supplementary Medical Insurance Trust  
 6 Fund)”;

7 (D) in subsection (i), by inserting after  
 8 “section 1840(b)(1)” the following: “, section  
 9 1859D(b)(2) (in which case the payments shall  
 10 come from the Prescription Drug Insurance Ac-  
 11 count in the Supplementary Medical Insurance  
 12 Trust Fund),”.

13 (2) PRESCRIPTION DRUG OPTION UNDER  
 14 MEDICARE+CHOICE PLANS.—

15 (A) Section 1851 (42 U.S.C. 1395w-21) is  
 16 amended—

17 (i) in subsection (a)(1)(A), by striking  
 18 “parts A and B” and inserting “parts A,  
 19 B, and D”; and

20 (ii) in subsection (i), by striking  
 21 “parts A and B” and inserting “parts A,  
 22 B, and D”.

23 (B) Section 1852(a)(1)(A) (42 U.S.C.  
 24 1395w-22(a)(1)(A)) is amended by inserting

1 “(and under part D to individuals also enrolled  
2 under that part)” after “parts A and B”.

3 (C) Section 1852(d)(1) (42 U.S.C.  
4 1395(d)(1)) is amended—

5 (i) by striking “and” at the end of  
6 subparagraph (D);

7 (ii) by striking the period at the end  
8 of subparagraph (E) and inserting “; and”  
9 and

10 (iii) by adding at the end the fol-  
11 lowing new subparagraph:

12 “(F) the plan for part D benefits guaran-  
13 tees coverage of any specifically named covered  
14 prescription drug for an enrollee, when pre-  
15 scribed by a physician in accordance with the  
16 provisions of such part, regardless of whether  
17 such drug would otherwise be covered under an  
18 applicable formulary or discount arrangement.”.

19 (D) Section 1854(e) (42 U.S.C. 1395w-  
20 4(e)) is amended by adding at the end the fol-  
21 lowing new paragraph:

22 “(5) SPECIAL RULE FOR PROVISION OF PART D  
23 BENEFITS.—In no event may a Medicare+Choice or-  
24 ganization include as part of a plan for part D bene-

1 fits a requirement that an enrollee pay a deductible,  
2 or a coinsurance percentage that exceeds 50 percent.

3 (E) Section 1857(d) (42 U.S.C. 1395w-  
4 27(d)) is amended by adding at the end the fol-  
5 lowing new paragraph:

6 “(6) AVAILABILITY OF NEGOTIATED PRICES.—  
7 Each contract under this section shall provide that  
8 enrollees who exhaust the plan’s prescription drug  
9 benefits will continue to have access to prescription  
10 drugs at negotiated prices equivalent to the total  
11 combined cost of such drugs to the plan and the en-  
12 rollee prior to such exhaustion of benefits.”.

13 (3) EXCLUSIONS FROM COVERAGE.—

14 (A) APPLICATION TO PART D.—Section  
15 1862(a) (42 U.S.C. 1395y(a)) is amended in  
16 the matter preceding paragraph (1) by striking  
17 “part A or part B” and inserting “part A, B,  
18 or D”.

19 (B) PRESCRIPTION DRUGS NOT EXCLUDED  
20 FROM COVERAGE IF APPROPRIATELY PRE-  
21 SCRIBED.—Section 1862(a)(1) (42 U.S.C.  
22 1395y(a)(1)) is amended—

23 (i) by striking “and” at the end of  
24 subparagraph (H);

1 (ii) by striking the semicolon at the  
 2 end of subparagraph (I) and inserting “,  
 3 and”; and

4 (iii) by adding after subparagraph (I)  
 5 the following new subparagraph:

6 “(J) in the case of prescription drugs cov-  
 7 ered under part D, which are not prescribed in  
 8 accordance with such part;

9 **SEC. 202. MEDICAID BUY-IN OF MEDICARE PRESCRIPTION**  
 10 **DRUG COVERAGE FOR CERTAIN LOW-INCOME**  
 11 **INDIVIDUALS.**

12 (a) STATE OPTION TO BUY-IN DUALY ELIGIBLE  
 13 INDIVIDUALS.—

14 (1) COVERAGE OF PREMIUMS AS MEDICAL AS-  
 15 SISTANCE.—Section 1905(a) (42 U.S.C. 1396d(a))  
 16 is amended in the fourth sentence by striking  
 17 “under part B” the first place it appears and insert-  
 18 ing “under parts B and D”.

19 (2) STATE COMMITMENT TO CONTINUE PAR-  
 20 TICIPATION IN PART D AFTER BENEFIT LIMIT  
 21 REACHED.—Section 1902(a) (42 U.S.C. 1396a(a))  
 22 is amended—

23 (A) by striking “and” at the end of para-  
 24 graph (64);

1 (B) by striking the period at the end of  
2 paragraph (65) and inserting “; and”; and

3 (C) by adding after paragraph (65) the fol-  
4 lowing new paragraph:

5 “(66) that, in the case of any individual  
6 whose eligibility for medical assistance is not  
7 limited to Medicare or Medicare drug cost shar-  
8 ing and for whom the State elects to pay pre-  
9 miums under part D of title XVIII pursuant to  
10 section 1859E, the State will purchase all pre-  
11 scription drugs for such individual in accord-  
12 ance with the provisions of such part D, with-  
13 out regard to whether the benefit limit for such  
14 individual under section 1859B(b) has been  
15 reached.”.

16 (b) MEDICARE COST SHARING REQUIRED FOR  
17 QUALIFIED MEDICARE BENEFICIARIES.—Section  
18 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended—

19 (1) in subparagraph (A)—

20 (A) by striking “and” at the end of clause  
21 (i);

22 (B) by inserting “and” at the end of clause  
23 (ii); and

24 (C) by adding after clause (ii) the fol-  
25 lowing:

1                   “(iii) premiums under section  
2                   1859D,”;

3                   (2) in subparagraph (D)—

4                   (A) by inserting “(i)” after “(D)”; and

5                   (B) by adding at the end the following:

6                   “(ii) The difference between the  
7                   amount that is paid under section 1859B  
8                   and the amount that would be paid under  
9                   such section if any reference to ‘50 per-  
10                  cent’ therein were deemed a reference to  
11                  ‘100 percent’ (or, if the Secretary approves  
12                  a higher percentage under such section, if  
13                  any reference to such percentage were  
14                  deemed to be multiplied by two).

15                  (c) MEDICARE DRUG COST SHARING REQUIRED FOR  
16                  MEDICARE-ELIGIBLE INDIVIDUALS WITH INCOMES BE-  
17                  TWEEN 100 AND 150 PERCENT OF POVERTY LINE.—

18                  (1) DEFINITIONS OF ELIGIBLE BENEFICIARIES  
19                  AND COVERAGE.—Section 1905 (42 U.S.C. 1396d)  
20                  is amended by adding at the end the following new  
21                  subsection:

22                  “(v)(1) The term ‘qualified medicare drug bene-  
23                  ficiary’ means an individual—

24                  “(A) who is entitled to hospital insurance bene-  
25                  fits under part A of title XVIII (including an indi-

1 individual entitled to such benefits pursuant to an en-  
2 rollment under section 1818, but not including an  
3 individual entitled to such benefits only pursuant to  
4 an enrollment under section 1818A),

5 “(B) whose income (as determined under sec-  
6 tion 1612 for purposes of the supplemental security  
7 income program, except as provided in subsection  
8 (p)(2)(D)) is above 100 percent but below 150 per-  
9 cent of the official poverty line (as defined by the  
10 Office of Management and Budget, and revised an-  
11 nually in accordance with section 673(2) of the Om-  
12 nibus Budget Reconciliation Act of 1981) applicable  
13 to a family of the size involved; and

14 “(C) whose resources (as determined under sec-  
15 tion 1613 for purposes of the supplemental security  
16 income program) do not exceed twice the maximum  
17 amount of resources that an individual may have  
18 and obtain benefits under that program.

19 “(2) The term ‘medicare drug cost-sharing’ means  
20 the following costs incurred with respect to a qualified  
21 medicare drug beneficiary, without regard to whether the  
22 costs incurred were for items and services for which med-  
23 ical assistance is otherwise available under the plan:

24 “(A) In the case of a qualified medicare drug  
25 beneficiary whose income (as determined under

1 paragraph (1)) is less than 135 percent of the offi-  
2 cial poverty line—

3 “(i) premiums under section 1859D; and

4 “(ii) the difference between the amount  
5 that is paid under section 1859B and the  
6 amount that would be paid under such section  
7 if any reference to ‘50 percent’ therein were  
8 deemed a reference to ‘100 percent’ (or, if the  
9 Secretary approves a higher percentage under  
10 such section, if any reference to such percent-  
11 age were deemed to be multiplied by two).

12 “(B) In the case of a qualified medicare drug  
13 beneficiary whose income (as determined under  
14 paragraph (1)) is at least 135 percent but less than  
15 150 percent of the official poverty line, a percentage  
16 of premiums under section 1859D, determined on a  
17 linear sliding scale ranging from 100 percent for in-  
18 dividuals with incomes at 135 percent of such line  
19 to 0 percent for individuals with incomes at 150 per-  
20 cent of such line.

21 “(3) In the case of any State which is providing med-  
22 ical assistance to its residents under a waiver granted  
23 under section 1115, the Secretary shall require the State  
24 to meet the requirement of section 1902(a)(10)(E) in the  
25 same manner as the State would be required to meet such

1 requirement if the State had in effect a plan approved  
2 under this title.”.

3 (2) STATE PLAN REQUIREMENT.—Section  
4 1902(a)(10)(E) (42 U.S.C. 1396(a)(10)(E)) is  
5 amended—

6 (A) by striking “and” at the end of clause  
7 (iii);

8 (B) by adding at the end the following new  
9 clause:

10 “(v) for making medical assistance  
11 available for medicare drug cost sharing  
12 (as defined in section 1905(v)(2)) for  
13 qualified medicare drug beneficiaries de-  
14 scribed in section 1905(v)(1); and”.

15 (3) 100 PERCENT FEDERAL MATCHING OF  
16 STATE MEDICAL ASSISTANCE COSTS FOR MEDICARE  
17 DRUG COST SHARING.—Section 1903(a) (42 U.S.C.  
18 1396b(a)) is amended—

19 (A) by redesignating paragraph (7) as  
20 paragraph (8); and

21 (B) by adding after paragraph (6) the fol-  
22 lowing new paragraph:

23 “(7) an amount equal to 100 percent of  
24 amounts as expended as medicare drug cost sharing  
25 for qualified medicare drug beneficiaries (as defined

1 in section 1905(v)) (except that this paragraph shall  
 2 not apply to amounts expended with respect to any  
 3 individual whose eligibility for medical assistance is  
 4 not limited to medicare or medicare drug cost shar-  
 5 ing); and”.

6 (d) MEDICAID DRUG PRICE REBATES UNAVAILABLE  
 7 WITH RESPECT TO DRUGS PURCHASED THROUGH MEDI-  
 8 CARE BUY-IN.—Section 1927 (42 U.S.C. 1396r–8) is  
 9 amended by adding at the end the following new sub-  
 10 section:

11 “(1) DRUGS PURCHASED THROUGH MEDICARE  
 12 BUY-IN.—The provisions of this section shall not  
 13 apply to prescription drugs purchased under part D  
 14 of title XVIII pursuant to an agreement with the  
 15 Secretary under section 1859E (including any drugs  
 16 so purchased after the limit under section 1859B(b)  
 17 has been exceeded).”.

18 (e) AMENDMENTS TO MEDICARE PART D.—Part D  
 19 of title XVIII, as added by section 201, is amended by  
 20 adding after section 1859D the following new section:

21 **“SEC. 1859E. SPECIAL ELIGIBILITY, ENROLLMENT, AND CO-  
 22 PAYMENT RULES FOR LOW-INCOME INDIVID-  
 23 UALS.**

24 “(a) STATE AGREEMENTS FOR COVERAGE.—

1           “(1) IN GENERAL.—The Secretary shall, at the  
2 request of a State, enter into an agreement with the  
3 State under which all individuals described in para-  
4 graph (2) are enrolled in the program under this  
5 part, without regard to whether any such individual  
6 has previously declined the opportunity to enroll in  
7 such program.

8           “(2) ELIGIBILITY GROUPS.—The individuals  
9 described in this paragraph, for purposes of para-  
10 graph (1), are individuals who satisfy section  
11 1859C(a) and who are—

12                   “(A)(i) eligible individuals within the  
13 meaning of section 1843, and

14                   “(ii) in a coverage group or groups per-  
15 mitted under section 1843 (as selected by the  
16 State and specified in the agreement); or

17                   “(B) qualified medicare drug beneficiaries  
18 (as defined in section 1905(v)(1)).

19           “(3) COVERAGE PERIOD.—The period of cov-  
20 erage under this part of an individual enrolled under  
21 an agreement under this subsection shall be as fol-  
22 lows:

23                   “(A) INDIVIDUALS ELIGIBLE (AT STATE  
24 OPTION) FOR PART B BUY-IN.—In the case of  
25 an individual described in subsection (a)(2)(A),

1 the coverage period shall be the same period  
 2 that applies (or would apply) pursuant to sec-  
 3 tion 1843(d).

4 “(B) QUALIFIED MEDICARE DRUG BENE-  
 5 FICIARIES.—In the case of an individual de-  
 6 scribed in subsection (a)(2)(B)—

7 “(i) the coverage period shall begin on  
 8 the latest of—

9 “(I) January 1, 2003,

10 “(II) the first day of the third  
 11 month following the month in which  
 12 the State agreement is entered into;  
 13 or

14 “(III) the first day of the first  
 15 month following the month in which  
 16 the individual satisfies section  
 17 1859C(a); and

18 “(ii) the coverage period shall end on  
 19 the last day of the month in which the in-  
 20 dividual is determined by the State to have  
 21 become ineligible for medicare drug cost-  
 22 sharing.

23 “(b) SPECIAL PART D ENROLLMENT OPPORTUNITY  
 24 FOR INDIVIDUALS LOSING MEDICAID ELIGIBILITY.—In  
 25 the case of an individual who—

1 “(1) satisfies section 1859C(a), and

2 “(2) loses eligibility for benefits under the State  
3 plan under title XIX after having been enrolled  
4 under such plan or having been determined eligible  
5 for such benefits,

6 the Secretary shall provide an opportunity for enrollment  
7 under the program under this part during the period that  
8 begins on the date that such individual loses such eligi-  
9 bility and ends on the date specified by the Secretary.

10 “(c) DEFINITION.—For purposes of this section, the  
11 term ‘State’ has the meaning given such term under sec-  
12 tion 1101(a) for purposes of title XIX.”.

13 PART B—IMPROVING PREVENTIVE BENEFITS AND  
14 ELIMINATING COST SHARING

15 **SEC. 221. ELIMINATION OF DEDUCTIBLES AND COINSUR-**  
16 **ANCE FOR PREVENTIVE BENEFITS.**

17 (a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l)  
18 is amended by adding after subsection (o) the following  
19 new subsection:

20 “(p) DEDUCTIBLES AND COINSURANCE WAIVED FOR  
21 PREVENTIVE BENEFITS.—Deductibles and coinsurance  
22 under subsections (a) and (b) shall not be required of indi-  
23 viduals covered under the insurance program under this  
24 part for any of the following preventive health care items  
25 and services:

1 “(1) blood-testing strips, lancets, and blood glu-  
2 cose monitors for individuals with diabetes described  
3 in section 1861(n);

4 “(2) diabetes outpatient self-management train-  
5 ing services described in section 1861(s)(2)(S);

6 “(3) pneumococcal, influenza, and hepatitis B  
7 vaccines and administration described in section  
8 1861(s)(10) ;

9 “(4) screening mammography as described in  
10 section 1861(s)(13);

11 “(5) screening pap smear and screening pelvic  
12 examinations as described in section 1861(s)(14);

13 “(6) bone mass measurement as described in  
14 section 1861(s)(15);

15 “(7) prostate cancer screening tests as defined  
16 in section 1861(oo); and

17 “(8) colorectal cancer screening as defined in  
18 section 1861(pp)(1).”.

19 (b) WAIVER OF COINSURANCE.—Section  
20 1833(a)(1)(B) (42 U.S.C. 1395l(a)(1)(B)) is amended by  
21 striking “items and services described in section  
22 1861(s)(10)(A)” and inserting “preventive care items and  
23 services described in subsection (p)”.

24 (c) WAIVER OF DEDUCTIBLE.—Section 1833(b) (42  
25 U.S.C. 1395l(b)) is amended in clause (1) to read as fol-

1 lows: “(1) such deductible shall not apply with respect to  
 2 preventive health care items and services specified in sub-  
 3 section (p)”.

4 (d) ADDING “LANCET” TO DEFINITION OF DME.—  
 5 Section 1861(n) (42 U.S.C. 1395x(n)) is amended by  
 6 striking “blood-testing strips and blood glucose monitors”  
 7 and inserting “blood-testing strips, lancets, and blood glu-  
 8 cose monitors ”.

9 (e) CONFORMING AMENDMENTS.—

10 (1) Section 1833(a)(1) (42 U.S.C. 1395l(a)(1))  
 11 is amended—

12 (A) in subparagraph (B)—

13 (i) by striking “section  
 14 1861(s)(10)(A)” and inserting “section  
 15 1833(p)”;

16 (ii) by striking “reasonable charges”  
 17 and inserting “of the fee schedule or other  
 18 basis of payment under this title”; and

19 (B) in subparagraphs (1)(D)(i) and  
 20 (2)(D)(i), by inserting “described in subsection  
 21 (p) or” after “in the case of such tests”.

22 (2) Section 1834(a)(1)(A) (42 U.S.C.  
 23 1395m(a)(1)(A)) is amended by inserting “(or 100  
 24 percent, in the case of such an item described in sec-  
 25 tion 1833(p))” after “80 percent”.

1           (3) Section 1834(c)(1)(C) (42 U.S.C.  
2 1395m(c)(1)(C)) is amended by striking “80 per-  
3 cent” and inserting “100 percent”.

4           (4) Section 1834(d) (42 U.S.C. 1395m(d)) is  
5 amended—

6           (A) in each of paragraphs (2)(C) and  
7 (3)(C)—

8                   (i) by striking clause (ii); and

9                   (ii) by striking all that precedes “sub-  
10 sections (i)(2)(A) and (t)” and inserting  
11 the following:

12                   “(C) FACILITY PAYMENT LIMIT.—Notwith-  
13 standing”, and adjusting margins accordingly;  
14 and

15           (B) in paragraph (2)(C), by redesignating  
16 subclauses (I) and (II) as clauses (i) and (ii).

17           (f) EFFECTIVE DATE.—The amendments made by  
18 this section shall be effective on and after January 1,  
19 2003.

20 **SEC. 222. INFORMATION CAMPAIGN ON PREVENTION.**

21           (a) REQUIRED ACTIVITIES.—The Secretary of  
22 Health and Human Services shall carry out, during 2002  
23 and 2003, a nationwide education campaign to promote  
24 preventive health awareness among older Americans and

1 people with disabilities, which shall include the following  
2 activities:

3 (1) An information campaign, in collaboration  
4 with the Social Security Administration, State health  
5 insurance assistance programs, area agencies on  
6 aging, and the private sector, designed to educate all  
7 Americans over age 50 and individuals with disabili-  
8 ties about the importance of preventive health care.

9 (2) Activities designed to encourage Medicare  
10 beneficiaries to use Medicare preventive benefits, in-  
11 cluding distribution of comprehensive information on  
12 Medicare preventive benefits to all Medicare bene-  
13 ficiaries.

14 (3) Development and testing of a health status  
15 assessment tool with follow-up interventions, to as-  
16 sist Medicare beneficiaries and their providers in  
17 identifying and mitigating health risks.

18 (4) A nationwide education and awareness cam-  
19 paign designed to educate older Americans on ad-  
20 justments to behavior and the home environment  
21 that can prevent falls.

22 (b) AUTHORIZATION OF APPROPRIATIONS.—Such  
23 sums as may be necessary to carry out this section are  
24 authorized to be appropriated for fiscal years 2002 and  
25 2003.

1 **SEC. 223. SMOKING CESSATION DEMONSTRATION.**

2 (a) IN GENERAL.—The Secretary shall, either di-  
3 rectly or through grants, contracts, or cooperative agree-  
4 ments, carry out a demonstration project testing a variety  
5 of smoking cessation services for Medicare beneficiaries,  
6 for the purpose of identifying the most successful and  
7 cost-effective approaches.

8 (b) DESIGN OF DEMONSTRATION.—

9 (1) IN GENERAL.—The Secretary shall deter-  
10 mine the design, implementation, and evaluation of  
11 the demonstration under this section, subject to the  
12 provisions of this section.

13 (2) SERVICES INCLUDED.—Services under the  
14 demonstration may include an initial patient assess-  
15 ment, counseling services, and any pharmacotherapy  
16 for smoking cessation approved by the Food and  
17 Drug Administration, and such other services as the  
18 Secretary may authorize. Services may be furnished  
19 by a person or entity that provides other services  
20 for which payment may be made under title XVIII  
21 of the Social Security Act, as well as by health edu-  
22 cators and other professionals in categories des-  
23 ignated by the Secretary who meet applicable certifi-  
24 cation and licensing requirements of State and local  
25 law.

1           (3) SCOPE AND DURATION.—Demonstration  
2 projects under this section shall be conducted at a  
3 minimum of four sites and shall not exceed five  
4 years in duration.

5           (c) Notwithstanding any provision of title XVIII of  
6 the Social Security Act (42 U.S.C. 1395 et seq.) or any  
7 other provision of law, in the case of smoking cessation  
8 items and services furnished to a Medicare beneficiary  
9 under a demonstration conducted by the Secretary under  
10 this section by an individual or entity authorized by the  
11 Secretary to participate in such demonstration—

12           (1) Such items and services shall be deemed to  
13 be health care items and services covered under the  
14 insurance programs under such title XVIII for pur-  
15 poses of payment from the Federal Health Insur-  
16 ance and Federal Supplementary Medical Insurance  
17 Trust Funds;

18           (2) Persons and entities furnishing smoking  
19 cessation items and services under a demonstration  
20 under this section shall be entitled to be paid from  
21 such Trust Funds an amount equal to the lesser of  
22 the actual cost of such items and services or the  
23 payment amount prescribed for such items or serv-  
24 ices under a fee schedule established by the Sec-  
25 retary; and

1           (3) The Secretary shall waive all coinsurance  
2           and deductibles under such title XVIII for smoking  
3           cessation items and services furnished under such  
4           demonstration.

5           (d) WAIVER AUTHORITY.—The Secretary is author-  
6           ized to waive the requirements of title XVIII of the Social  
7           Security Act (42 U.S.C. 1395 et seq.) to the extent and  
8           for the period the Secretary finds necessary to conduct  
9           the demonstration under this section.

10          (e) FUNDING.—The Secretary shall provide for the  
11          transfer from the Federal Health Insurance and Federal  
12          Supplementary Insurance Trust Fund of such funds as  
13          are necessary for the costs of carrying out and evaluating  
14          the demonstration projects under this section.

15          (f) EVALUATION; REPORT TO CONGRESS.—Upon  
16          conclusion of the demonstration, the Secretary shall cause  
17          the demonstration to be evaluated and shall submit to  
18          Congress a report including the following:

- 19                (1) A description of the demonstration.
- 20                (2) An assessment of—
- 21                    (A) patient outcomes, including smoking  
22                    “quit” rates;
- 23                    (B) the cost-effectiveness of the dem-  
24                    onstration; and

1 (C) the quality of the services furnished  
 2 through the demonstration, including measures  
 3 of beneficiary and provider satisfaction.

4 (3) A recommendation as to whether the dem-  
 5 onstration should be continued or expanded under  
 6 part B of such title XVIII, including, if the evalua-  
 7 tion has found the demonstration successful, rec-  
 8 ommendations as to the individuals who should be  
 9 eligible to receive smoking cessation benefits, the  
 10 persons and entities that should be authorized to  
 11 provide the benefits, the type and scope of benefits,  
 12 and appropriate payment methodologies.

13 (4) Any other information that the Secretary  
 14 determines to be appropriate.

15 **PART C—RATIONALIZING COST SHARING AND MEDIGAP**

16 **SEC. 231. DEDUCTIBLES AND COINSURANCE FOR CLINICAL**  
 17 **LABORATORY SERVICES.**

18 (a) **IN GENERAL.**—Section 1833, as amended by sec-  
 19 tion 221, is further amended—

20 (1) in subsection (a)—

21 (A) in paragraph (1)(D)—

22 (i) in clause (i), by striking the open  
 23 parenthesis an all that follows through “on  
 24 an assignment-related basis)”; and

1 (ii) in clause (ii), by striking “100  
2 percent” and inserting “80 percent (or 100  
3 percent, in the case of such tests described  
4 in subsection (p))”; and

5 (B) in paragraph (2)(D)—

6 (i) in clause (i), by striking the open  
7 parenthesis and all that follows through  
8 “section 1866” and inserting “such tests  
9 described in subsection (p)”; and

10 (ii) in clause (ii), by striking “100  
11 percent” and inserting “80 percent (or 100  
12 percent, in the case of such tests described  
13 in subsection (p))”; and

14 (2) in subsection (b)—

15 (A) by striking subparagraph (3); and

16 (B) by redesignating paragraphs (4)  
17 through (6) as paragraphs (3) through (5) re-  
18 spectively.

19 (b) EFFECTIVE DATE.—The amendments made by  
20 subsection (a) shall apply to tests furnished on or after  
21 January 1, 2003.

22 **SEC. 232. INDEXING DEDUCTIBLE TO INFLATION.**

23 Section 1833(b) (42 U.S.C. 1395l(b)) is amended by  
24 inserting after “1991 and subsequent years” the following:  
25 “, adjusted annually, effective January 1 of each year be-

1 ginning in 2003, by a percentage increase or decrease  
 2 equal to the percentage increase or decrease in the con-  
 3 sumer price index for all urban consumers (U.S. city aver-  
 4 age) for the 12-month period ending with June of the pre-  
 5 vious year, rounded to the nearest dollar”.

6 **SEC. 233. UPDATING AND EXPANDING MEDIGAP PLAN OP-**  
 7 **TIONS.**

8 (a) REVIEW AND UPDATE OF BENEFIT PACKAGES  
 9 FOR MEDIGAP POLICIES.—

10 (1) ESTABLISHMENT OF NEW MEDIGAP  
 11 PLAN.—

12 (A) IN GENERAL.—Section 1882(p)(1) (42  
 13 U.S.C. 1395ss(p)(1)) is amended by redesignig-  
 14 nating subparagraph (E) as subparagraph (F)  
 15 and inserting after subparagraph (D) the fol-  
 16 lowing new subparagraph:

17 “(E) (i) Within 9 months after enactment  
 18 of this subparagraph, the Association may re-  
 19 vise the 1991 NAIC Model Regulation to in-  
 20 clude a new plan ‘K’ that—

21 “(I) complies with paragraphs (2) and  
 22 (3);

23 “(II) except as provided in subclause  
 24 (III), requires the beneficiary of the policy  
 25 to pay—

1                   “(aa) nominal copayments; and  
2                   “(bb) all or a portion (not to be  
3                   less than 50 percent) of the part B  
4                   deductible under section 1833; and  
5                   “(III) in the case of beneficiaries  
6                   under the policy who are receiving services  
7                   under any of the programs specified in  
8                   paragraphs (1) through (4) of section  
9                   1866M(a), covers 100 percent of any cost-  
10                  sharing charges imposed on beneficiaries  
11                  under such program.

12                  If the Association so revises the 1991  
13                  NAIC Model Regulation, references to the  
14                  1991 NAIC Model Regulation in this sec-  
15                  tion shall be interpreted to refer to the  
16                  1991 NAIC Model Regulation as so re-  
17                  vised.

18                  “(ii) If the Association does not make the  
19                  changes in the revised NAIC Model Regulation  
20                  within the 9-month period specified in clause (i)  
21                  the Secretary shall provide for the establish-  
22                  ment of a new plan ‘K’ in accordance with the  
23                  provisions of subparagraph (B), and any re-  
24                  quirements applicable to a State under subpara-  
25                  graph (B) shall apply with respect to the estab-

1 lishment of the new plan under this subpara-  
2 graph.”.

3 (B) REQUIREMENT THAT ALL ISSUERS  
4 OFFER PLAN “K”.—

5 (i) IN GENERAL.—Section  
6 1882(p)(9)(A) (42 U.S.C.  
7 1395ss(p)(9)(A)) is amended by inserting  
8 before the period “and a medicare supple-  
9 mental policy described in paragraph  
10 (1)(E)”.

11 (ii) PROHIBITION ON STATE RESTRIC-  
12 TION.—Section 1882(p)(5)(B) (42 U.S.C.  
13 1395ss(p)(5)(B)) is amended by inserting  
14 before the period “or a medicare supple-  
15 mental policy described in paragraph  
16 (1)(E)”.

17 (C) CONFORMING AMENDMENTS.—Section  
18 1882(p) (42 U.S.C. 1395ss(p)) is amended in  
19 paragraph (2)(C) by striking “shall not exceed  
20 10” and inserting “shall not exceed 11”.

21 (2) PERIODIC REVIEW.—Section 1882(p)(1)(F)  
22 (42 U.S.C. 1395ss(p)(1)(F)) as redesignated, is  
23 amended—

1 (A) by striking all that precedes “the pre-  
2 ceding provisions of this paragraph” and insert-  
3 ing the following:

4 “(F) The Secretary, in consultation with  
5 the Association, shall periodically review stand-  
6 ard supplemental packages established pursuant  
7 to paragraph (2). If, on the basis of such con-  
8 sultation and review, the Secretary determines  
9 that changes in the 1991 NAIC Model Regula-  
10 tion or 1991 Federal Regulation (including  
11 changes in the content or number of packages  
12 established pursuant to paragraph (2), and in  
13 the provision or scope of drug benefits available  
14 under those packages), are needed to better re-  
15 flect the needs of beneficiaries under this title  
16 (including the need for affordable supplemental  
17 insurance options),”; and

18 (B) by adding at the end the following new  
19 sentence: “If the Secretary determines that it is  
20 necessary to change the benefit packages estab-  
21 lished under paragraph (2) to better reflect the  
22 needs of beneficiaries as described in this sub-  
23 paragraph, the Secretary shall, through a notice  
24 in the Federal Register, request the Association

1 to recommend such changes to the benefit pack-  
2 age as it considers appropriate.”.

3 (b) IMPROVED INFORMATION ON MEDIGAP.—Section  
4 1882(e) (42 U.S.C. 1395ss(e)) is amended by adding at  
5 the end the following new paragraph:

6 “(4) The Secretary shall provide to individuals  
7 entitled to benefits under this title (and, to the ex-  
8 tent feasible, individuals about to become so enti-  
9 tled) information allowing easy comparison of the  
10 supplemental insurance policies authorized under  
11 subsection (p)(2), including the benefits, premiums,  
12 and cost-sharing provisions of such policies.”.

13 **SEC. 234. REPORT TO CONGRESS ON OPTIONS FOR IM-**  
14 **PROVING MEDICARE SUPPLEMENTAL COV-**  
15 **ERAGE.**

16 (a) IN GENERAL.—The Secretary shall prepare and  
17 transmit to the Congress, not later than January 1, 2002,  
18 a detailed report that may include specific recommenda-  
19 tions on policy options for improving Medicare supple-  
20 mental coverage, with particular attention to means of  
21 limiting out-of-pocket costs for health care items and serv-  
22 ices covered under title XVIII of the Social Security Act  
23 (42 U.S.C. 1395 et seq.) .

24 (b) CONTENTS OF REPORT.—The report required  
25 under this section may—

1           (1) consider effects of beneficiaries' having mul-  
2           tiple sources of health care coverage (including du-  
3           plication of coverage and incentives for overutiliza-  
4           tion of services);

5           (2) compare total cost sharing by Medicare  
6           beneficiaries (under Medicare and Medicare supple-  
7           mental policies) with cost sharing by beneficiaries of  
8           private-sector health insurance;

9           (3) consider means of improving beneficiary in-  
10          formation on the comparative cost and quality of  
11          Medicare supplemental policies;

12          (4) consider options for structuring, and the  
13          feasibility and advisability (including the potential  
14          for reducing beneficiaries' out-of-pocket costs and  
15          unnecessary utilization) of alternatives including—

16                (A) optional unsubsidized supplemental  
17                coverage under Medicare requiring beneficiary  
18                cost-sharing; and

19                (B) a Medicare supplemental benefit, re-  
20                quiring beneficiary copayments, to be offered by  
21                private entities as a supplement to coverage  
22                under original Medicare as part of the competi-  
23                tive defined benefit program.

1 **SEC. 235. INCREASING ACCESS TO MEDIGAP.**

2 (a) APPLYING MEDIGAP PROTECTIONS TO DISABLED  
3 AND ESRD MEDICARE BENEFICIARIES.—

4 (1) OPEN ENROLLMENT PERIOD FOR DISABLED  
5 AND ESRD BENEFICIARIES.—

6 (A) IN GENERAL.—Section 1882(s) (42  
7 U.S.C. 1395ss(s)) is amended—

8 (i) in paragraph (2)(A), by striking  
9 “the 6 month period” and all that follows  
10 through the period and inserting “(i) the 6  
11 month period beginning with the first  
12 month as of the first day on which the in-  
13 dividual is first enrolled for benefits under  
14 part B of this subchapter; and (ii) if dif-  
15 ferent from the period specified in clause  
16 (i), the 6 month period beginning with the  
17 first month as of the first day on which  
18 the individual is 65 years of age or older  
19 and is enrolled for benefits under such part  
20 B.”;

21 (ii) in paragraph (2)(D), in the mat-  
22 ter preceding clause (i)—

23 (I) by striking “the 6-month pe-  
24 riod” and inserting “a 6-month pe-  
25 riod”; and

1 (II) by striking “who is 65 years  
2 of age or older as of the date of  
3 issuance and”; and

4 (iii) in paragraph (3)(B)(vi), by strik-  
5 ing “at age 65”.

6 (B) INITIAL OPEN ENROLLMENT PE-  
7 RIOD.—Section 1882(s)(2) (42 U.S.C.  
8 1395ss(s)), as amended by subparagraph (A), is  
9 amended by adding at the end the following  
10 new subparagraph:

11 “(E) In the case of an individual who, as  
12 of the effective date of enactment of this sub-  
13 paragraph, is enrolled for benefits under part B  
14 on the basis of disability or end-stage renal dis-  
15 ease and has not attained age 65, the 6 month  
16 period specified in subparagraph (A)(i) shall be  
17 deemed to be the 6 month period beginning on  
18 such date.”.

19 (2) REQUIREMENT THAT MEDIGAP ISSUERS  
20 OFFER POLICIES TO DISABLED AND ESRD BENE-  
21 FICIARIES.—Section 1882(s) (42 U.S.C. 1395ss(s))  
22 is amended—

23 (A) by redesignating paragraph (4) as  
24 paragraph (5); and

1 (B) by adding after paragraph (3) the fol-  
2 lowing new paragraph:

3 “(4) The issuer of a Medicare supplemental poli-  
4 cy that offers such policy to individuals who are 65  
5 years of age or older may not decline to offer such  
6 policy to individuals entitled to benefits under this  
7 title pursuant to section 226(b) or 226A.”.

8 (3) RATING STANDARDS FOR POLICIES ISSUED  
9 TO DISABLED AND ESRD BENEFICIARIES.—Section  
10 1882(s) (42 U.S.C. 1395ss(s)), as amended by para-  
11 graph (2), is amended—

12 (A) by redesignating paragraph (5) as  
13 paragraph (6); and

14 (B) by adding after paragraph (4) the fol-  
15 lowing new paragraph:

16 “(5)(A) The Secretary shall request the Na-  
17 tional Association of Insurance Commissioners (in  
18 this paragraph referred to as the ‘Association’) to  
19 develop and publish model standards for rating  
20 Medicare supplemental policies for individuals who  
21 are under age 65. Such standards shall be designed  
22 to ensure affordable access to such policies for such  
23 individuals while avoiding, to the greatest extent  
24 possible, disruptions in the market for Medicare sup-  
25 plemental policies.”.

1           (4) EFFECTIVE DATE.—The amendments made  
2           by paragraphs (1), (2), and (3) are effective 30 days  
3           after enactment of this Act.

4           (b) SPECIAL MEDIGAP ENROLLMENT ANTIDISCRIMI-  
5 NATION PROVISION FOR CERTAIN BENEFICIARIES.—

6           (1) DISENROLLMENT WINDOW IN ACCORDANCE  
7           WITH BENEFICIARY’S CIRCUMSTANCE.—Section  
8           1882(s)(3) is amended—

9                   (A) in subparagraph (A), by striking “not  
10                   later than 63 days after the date of termination  
11                   of enrollment described in such subparagraph”  
12                   and inserting “during the period specified in  
13                   subparagraph (E)”; and

14                   (B) by adding at the end the following new  
15                   subparagraph:

16                           “(E) For purposes of subparagraph (A),  
17                           the time period specified in this subsection in  
18                           the case of an individual—

19                                   “(i) described in clause (i) of subpara-  
20                                   graph (B), is the period beginning on the  
21                                   date the individual receives a notice of ter-  
22                                   mination or cessation of all supplemental  
23                                   health benefits or, if no such notice is re-  
24                                   ceived, notice that a claim has been denied

1 because of such a termination or cessation  
2 and ending 63 days thereafter;

3 “(ii) described in clause (ii), (iii), (v),  
4 or (vi) of subparagraph (B) whose enroll-  
5 ment is terminated involuntarily, is the pe-  
6 riod beginning on the date that the indi-  
7 vidual receives a notice of termination and  
8 ending on the date 63 days after the date  
9 coverage ends;

10 “(iii) described in clause (iv)(I), is the  
11 period beginning on the earlier of (I) the  
12 date that the individual receives a notice of  
13 termination, a notice of the issuer’s bank-  
14 ruptcy or insolvency, or other such similar  
15 notice, if any, and (II) the date that cov-  
16 erage ends, and ending on the date 63  
17 days after the date coverage ends;

18 “(iv) described in clause (ii), (iii),  
19 (iv)(II), (iv)(III), (v), or (vi) of subpara-  
20 graph (B) who disenrolls voluntarily, is the  
21 period beginning on the date 60 days be-  
22 fore and ending on the date 63 days after,  
23 the effective date of disenrollment; and

24 “(v) described in subparagraph (B),  
25 but not described in the preceding provi-

1           sions of this subparagraph, is the period  
2           beginning on the effective date of  
3           disenrollment and ending on the date 63  
4           days thereafter.”.

5           (2) EXTENDED MEDIGAP ACCESS FOR INTER-  
6           RUPTED TRIAL PERIODS.—Section 1882(s)(3), as  
7           amended by paragraph (1), is further amended by  
8           adding at the end the following new subparagraph:

9           “(F) For purposes of this paragraph—

10           “(i) in the case of an individual de-  
11           scribed in subparagraph (B)(v) (or deemed  
12           to be so described, pursuant to this sub-  
13           paragraph) whose enrollment with an orga-  
14           nization described in subparagraph  
15           (B)(v)(II) is involuntarily terminated with-  
16           in the first 12 months of such enrollment,  
17           and who, without an intervening enroll-  
18           ment, enrolls with another such organiza-  
19           tion, such subsequent enrollment shall be  
20           deemed to be an initial enrollment de-  
21           scribed in such clause (v); and

22           “(ii) in the case of an individual de-  
23           scribed in subparagraph (B)(vi) (or  
24           deemed to be so described, pursuant to this  
25           subparagraph) whose enrollment with a

1 plan described in subparagraph (B)(v)(II)  
 2 is involuntarily terminated within the first  
 3 12 months of such enrollment, and who,  
 4 without an intervening enrollment, enrolls  
 5 in another such plan, such subsequent en-  
 6 rollment shall be deemed to be an initial  
 7 enrollment described in such clause (vi).”.

8 (c) ONE-TIME ADDITIONAL SPECIAL OPEN ENROLL-  
 9 MENT FOR BENEFICIARIES LOSING ACCESS TO  
 10 MEDICARE+CHOICE PLANS.—

11 (1) IN GENERAL.—An issuer of a medicare sup-  
 12 plemental policy must comply with the conditions of  
 13 clauses (i) through (iii) of section 1882(s)(3)(A) in  
 14 the case of an individual described in paragraph (2)  
 15 who seeks to enroll under the policy not later than  
 16 92 days after the date of enactment of this section.

17 (2) CONDITIONS OF ELIGIBILITY.—

18 (A) IN GENERAL.—For purposes of para-  
 19 graph (1), an individual is described in this  
 20 paragraph if—

21 (i) the individual’s enrollment with an  
 22 organization—

23 (I) described in clause (i) or (ii)  
 24 of subparagraph (B) is terminated be-

1 cause of a circumstance described in  
2 section 1851(e)(4)(A); or

3 (II) described in clause (iii) of  
4 subparagraph (B) is terminated on or  
5 before December 31, 1998 because of  
6 such a circumstance;

7 (ii) the individual is not enrolled—

8 (I) with another organization de-  
9 scribed in subparagraph (B); or

10 (II) under a medicare supple-  
11 mental policy; and

12 (iii) the individual submits evidence of  
13 the date of termination or disenrollment  
14 along with the application for such medi-  
15 care supplemental policy.

16 (B) APPLICABLE ORGANIZATIONS.—For pur-  
17 poses of subparagraph (A), an organization de-  
18 scribed in this subparagraph is—

19 (i) an eligible organization under a  
20 contract under section 1876 or a similar  
21 organization operating under a demonstra-  
22 tion project authority;

23 (ii) an organization under an agree-  
24 ment under section 1833(a)(1)(A); or

1 (iii) a Medicare+Choice organization  
2 under a Medicare+Choice plan under part  
3 C.

4 (d) GUARANTEED ACCESS FOR CERTAIN MEDICARE  
5 BENEFICIARIES TO ALL SUPPLEMENTAL POLICIES.—Sec-  
6 tion 1882(s)(3)(C)(iii) (42 U.S.C. 1395ss(s)(3)(C)(iii)) is  
7 amended by inserting “or an individual described in sub-  
8 paragraph (B)(ii) or (B)(iii) in the case of circumstances  
9 permitting discontinuance of the individual’s election  
10 under section 1851(e)(4)(A)” after “subpara-  
11 graph(B)(vi)”.

12 (e) INCREASED CIVIL MONEY PENALTIES FOR VIO-  
13 LATION OF OPEN ENROLLMENT REQUIREMENT.—Section  
14 1882(s)(4) (42 U.S.C. 1395ss(s)(4)) is amended by strik-  
15 ing “the requirements of this subsection is subject to a  
16 civil money penalty of not to exceed \$5,000 for each such  
17 failure” and inserting “any requirement of this subsection  
18 with respect to any individual is subject to a civil money  
19 penalty of not to exceed \$50,000 for each such failure with  
20 respect to such individual, plus an additional civil money  
21 penalty of not to exceed \$5,000 for each day such failure  
22 continues with respect to such individual”.

23 (f) TRANSITION PROVISIONS.—The provisions of sec-  
24 tion 4031(e) of the Balanced Budget Act of 1997 shall

1 apply to the amendments made by this section in the same  
2 manner as they apply to such section 4031, except that—

3           (1) the reference in such section 4031(e) to “9  
4 months after the date of the enactment of this Act”  
5 shall be considered to be a reference to 9 months  
6 after the effective date of this section;

7           (2) the reference in such section 4031(e) to the  
8 “1991 NAIC Model Regulation, as modified pursu-  
9 ant to section 171(m)(2) of the Social Security Act  
10 Amendments of 1994 (Public Law 103–432) and as  
11 modified pursuant to section 1882(d)(3)(A)(vi)(IV)  
12 of the Social Security Act, as added by section  
13 271(a) of the Health Insurance Portability and Ac-  
14 countability Act of 1996 (Public Law 104–191)”  
15 shall be considered to be a reference to the 1991  
16 NAIC Model Regulation, as modified pursuant to all  
17 statutes enacted prior to the enactment of this sec-  
18 tion; and

19           (3) any reference to “1999” in such section  
20 4031(e) shall be considered to be a reference to  
21 2002 for purposes of the amendments made by this  
22 section.

1 **SEC. 236. REMOVAL OF SUNSET DATE FOR COST-SHARING**  
2 **IN MEDICARE PART B PREMIUMS FOR CER-**  
3 **TAIN QUALIFYING INDIVIDUALS.**

4 (a) IN GENERAL.—Section 1902(a)(10)(E)(iv) (42  
5 U.S.C. 1396a(a)(10)(E)(iv)) is amended—

6 (1) by striking subclause (II);

7 (2) by amending the text preceding subclause  
8 (I) to read as follows:

9 “(iv) subject to section 1905(p)(4),  
10 for making medical assistance available”;

11 (3) by striking subclause designation “(I)”, re-  
12 locating the remaining text at the end of clause (iv),  
13 and indenting appropriately; and

14 (4) by striking “, and” at the end of clause (iv),  
15 as so amended, and inserting “; and”.

16 (b) RELOCATION OF PROVISION REQUIRING 100  
17 PERCENT FEDERAL MATCHING OF STATE MEDICAL AS-  
18 SISTANCE COSTS FOR CERTAIN QUALIFYING INDIVID-  
19 UALS.—Section 1903(a) (42 U.S.C. 1395b(a)), as amend-  
20 ed by section 202(c)(3), is amended—

21 (1) by redesignating paragraph (8) as para-  
22 graph (9); and

23 (2) by adding after paragraph (7) the following  
24 new paragraph:

25 “(8) an amount equal to 100 percent of  
26 amounts as expended as medicare drug cost sharing

1 for individuals described in section  
2 1903(a)(10)(E)(iv);”.

3 (c) REPEAL OF SECTION 1933.—Section 1933 (42  
4 U.S.C. 1396u–3) is repealed.

5 (d) EFFECTIVE DATE.—The amendments made by  
6 this section shall be effective on and after January 1,  
7 2003.

8 **TITLE III—PROTECTING AND EX-**  
9 **TENDING MEDICARE SOL-**  
10 **VENCY**

11 **SEC. 301. TRANSFERS TO EXTEND MEDICARE SOLVENCY.**

12 Section 1817 (42 U.S.C. 1395i) is amended by add-  
13 ing at the end the following new subsection:

14 “(l) Additional Appropriation to Federal Hospital In-  
15 surance Trust Fund.—

16 “(1) In addition to any other amounts appro-  
17 priated to the Trust Fund, there is hereby appro-  
18 priated to the Trust Fund, out of any moneys in the  
19 Treasury not otherwise appropriated—

20 “(A) for the fiscal year ending September  
21 30, 2001, \$15,400,000,000;

22 “(B) for the fiscal year ending September  
23 30, 2002, \$12,600,000,000;

24 “(C) for the fiscal year ending September  
25 30, 2006, \$26,000,000,000;

1           “(D) for the fiscal year ending September  
2           30, 2007, \$47,000,000,000;

3           “(E) for the fiscal year ending September  
4           30, 2008, \$57,000,000,000;

5           “(F) for the fiscal year ending September  
6           30, 2009, \$61,000,000,000;

7           “(G) for the fiscal year ending September  
8           30, 2010, \$80,000,000,000;

9           “(H) for the fiscal year ending September  
10          30, 2011, \$22,400,000,000;

11          “(I) for the fiscal year ending September  
12          30, 2012, \$29,500,000,000;

13          “(J) for the fiscal year ending September  
14          30, 2013, \$32,000,000,000;

15          “(K) for the fiscal year ending September  
16          30, 2014, \$26,200,000,000;

17          “(L) for the fiscal year ending September  
18          30, 2015, \$13,800,000,000.

19          “(2) The amounts appropriated for each fiscal  
20          year by paragraph (1) shall be transferred from the  
21          general fund in the Treasury to the Trust Fund in  
22          equal monthly installments on the first business day  
23          of each month.”.

1 **SEC. 302. CATASTROPHIC PRESCRIPTION DRUG COVERAGE**

2 **RESERVE.**

3 (a) ESTABLISHMENT OF RESERVE.—There is estab-  
4 lished a reserve fund which shall be known as the “Cata-  
5 strophic Prescription Drug Coverage Reserve,” as defined  
6 in section 3(11) of the Congressional Budget Act of 1974,  
7 as amended by this Act.

8 (b) DEFINITION.—Section 3 of the Congressional  
9 Budget Act of 1974 is amended by adding at the end the  
10 following:

11 “(11) The term ‘Catastrophic Prescription  
12 Drug Coverage Reserve’ means—

13 “(A) for fiscal year 2006, \$4,000,000,000;

14 “(B) for fiscal year 2007, \$5,000,000,000;

15 “(C) for fiscal year 2008, \$6,800,000,000;

16 “(D) for fiscal year 2009, \$8,400,000,000;

17 and

18 “(E) for fiscal year 2010,

19 \$10,800,000,000.”.

20 (c) DISPOSITION OF RESERVE FUND.—Beginning  
21 with September 30, 2006, any balance remaining in the  
22 Catastrophic Prescription Drug Coverage Reserve on the  
23 last day of a fiscal year is appropriated to the Federal  
24 Hospital Insurance Trust Fund.

1 **SEC. 303. MEDICARE SOLVENCY DEBT REDUCTION RE-**  
2 **SERVE.**

3 (a) IN GENERAL.—Both the transfers under section  
4 1817(1) of the Social Security Act as well as amounts  
5 placed in reserve for catastrophic prescription drug cov-  
6 erage under section 3(11) of the Congressional Budget  
7 Act shall be known as the Medicare Solvency Debt Reduc-  
8 tion Reserve.

9 (b) POINTS OF ORDER TO PROTECT RESERVE.—

10 (1) Section 301 of the Congressional Budget  
11 Act of 1974 is amended by adding at the end the  
12 following:

13 “(j) POINT OF ORDER TO PROTECT MEDICARE SOL-  
14 VENCY DEBT REDUCTION RESERVE.—

15 “(1) IN GENERAL.—It shall not be in order in  
16 the House of Representatives or the Senate to con-  
17 sider any concurrent resolution on the budget (or  
18 amendment, motion, or conference report on the res-  
19 olution) that would allocate any amount of, or as-  
20 sume a reduction in the Medicare Solvency Debt Re-  
21 duction Reserve.

22 “(2) INAPPLICABILITY.—This subsection shall  
23 not apply to legislation that appropriates funds from  
24 the Catastrophic Prescription Drug Coverage Re-  
25 serve for catastrophic prescription drug benefits  
26 under the Medicare program.”

1           (2) Section 311(a) of the Congressional Budget  
2 Act of 1974 is amended by adding at the end the  
3 following:

4           “(4) ENFORCEMENT OF MEDICARE SOLVENCY  
5 RESERVE.—

6           “(A) IN GENERAL.—It shall not be in  
7 order in the House of Representatives or the  
8 Senate to consider any bill, joint resolution,  
9 amendment, motion, or conference report that  
10 would cause a decrease in the level of the Medi-  
11 care Solvency Debt Reduction Reserve.

12           “(B) INAPPLICABILITY.—This paragraph  
13 shall not apply to legislation that appropriates  
14 a portion of the Medicare Solvency Debt Reduc-  
15 tion Reserve for new amounts for Medicare or  
16 catastrophic prescription drug benefits under  
17 the Medicare program.”.

18           (c) SUPER MAJORITY REQUIREMENT.—

19           (1) Section 904(c)(2) of the Congressional  
20 Budget Act of 1974 is amended by inserting  
21 “301(j),” after “301(i),”.

22           (2) Section 904(d)(3) of the Congressional  
23 Budget Act of 1974 is amended by inserting  
24 “301(j),” after “301(i),”.

1 **SEC. 304. PROTECTION OF MEDICARE SOLVENCY DEBT RE-**  
2 **DUCTION RESERVE.**

3 (a) REDUCTION OF MEDICARE SOLVENCY TRANS-  
4 FERS, OR CATASTROPHIC PRESCRIPTION DRUG RESERVE  
5 NOT TO BE COUNTED AS PAY-AS-YOU-GO OFFSET.—  
6 Any provision of legislation that would reduce, repeal, or  
7 reverse the transfers to the Hospital Insurance Trust  
8 Fund under section 1817(1) of the Social Security Act or  
9 the amount of the Catastrophic Prescription Drug Cov-  
10 erage Reserve under section 3(11) of the Congressional  
11 Budget Act, shall not be counted on the pay-as-you-go  
12 scorecard and shall not be included in any pay-as-you-go  
13 estimates made by the Congressional Budget Office or the  
14 Office of Management and Budget under section 252 of  
15 the Balanced Budget and Emergency Deficit Control Act  
16 of 1985.

17 (b) CONFORMING CHANGE.—Section 252 of the Bal-  
18 anced Budget and Emergency Deficit Control Act of 1985  
19 is amended, in paragraph (4) of subsection (d), by—

20 (1) striking “and” after subparagraph (A),

21 (2) striking the period after the subparagraph  
22 (B) and inserting “; and”, and

23 (3) adding the following:

24 “(C) provisions that reduce, repeal, or re-  
25 verse transfers under section 1817(1) of the So-  
26 cial Security Act or the amount of the reserve

1           under section 3(11) of the Congressional Budg-  
2           et Act.”.

3           (c) MEDICARE SOLVENCY TRANSFERS AND CATA-  
4 STROPHIC PRESCRIPTION DRUG RESERVE REDUCE ON-  
5 BUDGET SURPLUS.—The transfers under section 1817(1)  
6 of the Social Security Act and amounts placed in the re-  
7 serve under section 3(11) of the Congressional Budget  
8 Act, together known as the “Medicare Solvency Debt Re-  
9 duction Reserve”, shall be treated for purposes of the  
10 President’s budget under title 31, United States Code, the  
11 Balanced Budget and Emergency Deficit Control Act of  
12 1985, and the Congressional Budget Act of 1974 as reduc-  
13 tions to the on-budget surplus (or increases in the on-  
14 budget deficit).

○